DEPT.- 65

JOB- 21

REEL- 38

CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

VP 23007

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health, BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals.

D. [X] Microfilm and retain originals for length of time indicated below

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber, M.D. Title: Commissioner of Health 3/18/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A. To be sold as scrap or waste paper	B. To be Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference)
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ]	[X]	[ ]

REMARKS: 2 negative Rolls

C. P. Force Records Management Officer 3/18/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR — Howard C. Zapf

2. APPROVED: CITY SOLICITOR — Thomas P. Bond

3. APPROVED: CITY COMPTROLLER — Hyman A. Pressman

4. APPROVED: CITY TREASURER — John E. Mowinckel

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS — Bernard Tschudy

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM — W. T. Hunter, Jr. / Carl W. Hunter II

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

D44904 HEALTH DEPARTMENT—CITY OF BALTIMORE D44904

CERTIFICATE OF DEATH.

1-PLACE OF DEATH, Univ Md Hospital 21 175-0 REGISTERED NO. C

CITY OF BALTIMORE (No. ST.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Grafton

(Residence in Baltimore: No. 722 W Hamburg. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M | 4-COLOR OR RACE, W. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, 12 (Month) — 22 (Day), 1893 (Year)

7-AGE 26 yrs. 6 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Glass blower.
(b) General nature of industry, business, or establishment in which employed (or employer)..... - - 086

9-BIRTHPLACE, (State or Country) Not known

PARENTS.

10-NAME OF FATHER, G. A Grafton

11-BIRTHPLACE OF FATHER (State or Country) Not known

12-MAIDEN NAME OF MOTHER Annie Miller.

13-BIRTHPLACE OF MOTHER (State or Country) Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. A. Grafton

(Address) 722 W Hamburg St.

15-

Filed JUL 19 1920 191.... G. H. Grese

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7 (Month) — 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Comp. Com. Fracture Skull.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Auto Accident

(Duration) yrs. mos. ds.

(Signed) Geo Edwin Wades M. D.
(Coroner.)

7/17/20 (Address) 143 N Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery | DATE OF BURIAL, July 19, 20

20-UNDERTAKER, James Pearce Grant Son | ADDRESS 100 S Paca St

CAUSE OF DEATH must be plainly written, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 44905 ✓ X55 D 44905

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Catherine Howett.

(a) RESIDENCE. NO. Wittman Maryland ST., WARD. St Michaels Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28, 1904.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William F Howett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Olive Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Wm F Howett
(Address) St Michaels

15 Filed JUL 19 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1920

17 I HEREBY CERTIFY, That I attended deceased from July 9 1920, to July 19, 1920, that I last saw h[illegible] alive on July 19 1920, and that death occurred, on the date stated above, at 6.15 A m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Microscopic.

(Signed) H Winslow, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Michaels Md	7/19/20

20 UNDERTAKER W H & J Jackson & Son ADDRESS North & Paca Sts

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D44906

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D44906

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 557 Mont ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E. Evans

(Residence in Baltimore: No. 557 Mont St.: yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	black	widow

6-DATE OF BIRTH, July 4, 1840
(Month) (Day) (Year)

7-AGE, 80 yrs. ..... mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... retired cook
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0 7 1

9-BIRTHPLACE, (State or Country) Harford Co. Md

PARENTS.

10-NAME OF FATHER, Frank Stokes

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Kathryn Ames

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie F. Dickerson

(Address) 552 Mont St

15- Filed JUL 19 1920 G. H. Grese.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 16, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest, and from inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Hennessy M. D.
(Coroner.)

July 16, 1920 (Address) 2807 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL, July 19, 1920
Laurel Cem	
20-UNDERTAKER Samuel Wendt	ADDRESS 578 N Eden

CAUSE OF DEATH to be filled in plain terms, so that it may be properly classified. Care in answering questions is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 44907

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44907

CERTIFICATE OF DEATH.

REGISTERED No. C 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Russell St ST.; Westminster WARD) 25

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresa Williams

(Residence in Baltimore: No. Russell st Hollander St.; 54 yrs., 5 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb 18, 1866 (Month) (Day) (Year)

7-AGE, (yrs. 54) (mos. 5) (ds. 5)

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph L Douglass

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eliza Jones Douglass

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Mowbray

(Address) Russell St Baltimore

15- JUL 19 1920 G. H. Grese.

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 14, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 16 1920, to July 14 1920, that I saw her alive on July 14 1920, and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Intersticular Pneumonia

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Thos B Hyatt M. D.

7-18-, 1920 (Address) Halethorp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. .....mos .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, July 19 1920

20-UNDERTAKER Samuel Lemley ADDRESS 1518 N Eutaw St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1009 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44908 — CERTIFICATE OF DEATH Bobnis — 382 D 44908

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bubnis

(a) RESIDENCE. NO. 1316 Glyndon Ave ST.: WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Francis Bubnis

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife

(b) General nature of Industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Simon Povilaitis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Mary Laukaitis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Francis Bubnis
(Address) 1316 Glyndon Ave.

15 Filed JUL 19 1920 G. H. Crese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1920

17

I HEREBY CERTIFY, That I attended deceased from June 26, 1920, to July 16, 1920, that I last saw her alive on July 16, 1920, and that death occurred, on the date stated above, at 3.55 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis and a Septicemia (Pelvic abscess) MDN

(duration) ....yrs. ....mos. 30 ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) ....yrs. ....mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 26, 1920

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) [illegible] M. D.

7/16 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	July 20 1920
20 UNDERTAKER	ADDRESS
Geo Leimbach & Son	6 [illegible]

TION is very important. See instructions on back of certificates.

D44909 HEALTH DEPARTMENT—CITY OF BALTIMORE D44909

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 809 Elder alley ST. 17 WARD) 105 REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Dennis

(Residence in Baltimore: No. 809 Elder alley St.; 27 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): widow

6-DATE OF BIRTH, ... Unknown ....., 1882
(Month) (Day) (Year)

7-AGE: 38 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, Isaac Eldridge

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Conquest

(Address) 920 N. Gay St.

15- Filed JUL 19 1920 19[illegible] G. H. Gresse Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July 16., 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... inquest .....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ..... inquest .....
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) J. S. Hennessy M. D.
(Coroner.)

July 15, 1920 (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mantes Va. DATE OF BURIAL, July 21 1920

20-UNDERTAKER Samuel Tokesley & T. W. Riddle ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION must be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D44910

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44910

D44910

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1345 N. Stricker ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sylvia E. Clay

(Residence in Baltimore: No. 1345 N. Stricker St.; yrs., 11 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, ... January (Month) 25 (Day), 1919 (Year)

7-AGE, ... yrs. 11 mos. 22 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country) Baltimore, Md.

PARENTS.

10-NAME OF FATHER, James H. Clay

11-BIRTHPLACE OF FATHER (State or Country) Baltimore, Md.

12-MAIDEN NAME OF MOTHER Edith Wallace

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H. Clay

(Address) 1345 N. Stricker St.

15- JUL 19 1920 G. H. Grese.

Filed ....., 191.....

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July (Month) 17 (Day), 1920 (Year)

I HEREBY CERTIFY, That I attended deceased from July 12 1920, to July 17, 1920, that I saw her alive on July 13, 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John D. Chesney M. D.

July 17, 1920 (Address) 1507 N. Fulton Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cem	July 19, 1920
20-UNDERTAKER	ADDRESS
Wm. R. Chandler	400 Myrtle

Spec.—8-24-14—M. & T.—2000 Bks.

D 44971

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 44911

REGISTERED No. C 22 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 N. Charles ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kate Kuhns

(Residence in Baltimore: No. 923 N. Charles St. St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) (Day) 1856 (Year)

7-AGE, 64 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Michael Hoffman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Kate Kuhns

(Address) 923 N. Charles St.

15- Filed JUL 19 1920 191 G. H. Grese. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 17, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 9 191 , to July 17 1920 , that I saw h alive on July 17 1920 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) yrs. mos. ds.

(Signed) Wm. Brumbaugh M. D.

July 19, 191 (Address) 923 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cemetery — DATE OF BURIAL, 7-21, 1920

20-UNDERTAKER Wm. J. E. Groom Son — ADDRESS 1720 Eutaw

CAUSE OF DEATH must be stated in plain English. Indefinite terms, such as "Heart Failure," "Exhaustion," "Blood Poisoning," "Pneumonia," "Cancer," "Tumor," "Abscess," "Paralysis," "Convulsions," "Fever," "Infection," "Septicemia," "Uremia," "Debility," "Old Age," "Childbirth," "Accident," "Injury," "Operation," "Malpractice," "Unknown," "Suicide," "Homicide," are not sufficient. Deaths from violence must state the means of injury, and whether accidental, suicidal, or homicidal. Deaths from childbirth must state the duration of pregnancy and whether single or multiple. Deaths from cancer must state the location and duration. Deaths from tumor must state the location, character, and duration. Deaths from tuberculosis must state the organ affected. Deaths from specific diseases must state the name of the disease. Deaths from paralysis must state the character and duration. Deaths from convulsions must state the character and duration. Deaths from fever must state the name of the disease, duration, and temperature. Deaths from infection must state the name of the disease. Deaths from septicemia must state the name of the disease. Deaths from uremia must state the duration. Deaths from debility must state the duration. Deaths from old age must state the duration. Deaths from childbirth must state the duration of pregnancy and whether single or multiple. Deaths from accident must state the means of injury. Deaths from injury must state the means of injury. Deaths from operation must state the name of the operation and the disease for which it was performed. Deaths from malpractice must state the name of the disease and the name of the person who performed the operation. Deaths from unknown must state the duration. Deaths from suicide must state the means of injury. Deaths from homicide must state the means of injury.

Please write plainly in ink. Fill out all items. Use "None" or "Unknown" where necessary. Do not use abbreviations or ditto marks. Be sure to sign certificate. Return to Health Department, Room 100, City Hall, Baltimore, Md. Read carefully the instructions on back of certificate. Every item is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 44912

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 44912

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 N Greene ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Louise Duthie

(a) RESIDENCE. No. 303 N Greene ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 9 mos. 3 ds. How long in U. S., if of foreig. birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm K Duthie

6 DATE OF BIRTH (month, day, and year) Oct 13, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country) U S

PARENTS

10 NAME OF FATHER Hugo Bruhn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm K Duthie (Address) 303 N Greene St

15 Filed JUL 19 1920 G. H. Gresse. Registrar

MEDICAL CERTIFICATE OF DEATH:

16 DATE OF DEATH (month, day, and year) July 16 1920

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1920, to July 16, 1920, that I last saw her alive on July 16, 1920, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

acute dilatation of heart

(duration) —yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(duration) unknown mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chester Roland, M. D.

7-16, 1920 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 19 1920
20 UNDERTAKER	ADDRESS
W M Rowlson	230 N Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly coded. ATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 44913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44913

CERTIFICATE OF DEATH.

45

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 S. Kenwood Ave ST.) (1st WARD)

2-FULL NAME Charles. Wolf.

(a) RESIDENCE. NO. 1011 S. Kenwood Ave., 1st WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22, 1878.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	11	25.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work File Driver 886

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer Sanford + Brooks.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Conrad H. Wolf.

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Minnie Sharper.

13 BIRTHPLACE OF MOTHER (city or town) Hanover (State or country) Germany.

14 Informant Mrs Minnie Wolf Mother
(Address) 1011 S Kenwood Ave.

15 Filed JUL 19 1920 G. H. Grese Registrar

CAUSE OF DEATH (In plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1 1920 to July 17 1920 that I last saw h in alive on July 17 1920 and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(duration) 3 mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) Wm McCarty, M. D.

7/19. 1920 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel.	July 20 1920
20 UNDERTAKER	ADDRESS
A. Heemann.	32 S Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44914

D 44914

CERTIFICATE OF DEATH.

74

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 E Lanvale ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter D. Bell

(a) RESIDENCE. NO. 418 E Lanvale ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Bell

6 DATE OF BIRTH (month, day, and year) Jan 2, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Walter Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky

12 MAIDEN NAME OF MOTHER Annie Dennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elizabeth Bell
(Address) 418 E Lanvale

15 Filed JUL 19 1920 G. L. Greene Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 19 20

17 I HEREBY CERTIFY, That I attended deceased from July 7 1920, to July 17 1920, that I last saw h alive on July 17 1920 and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:

Cerebral Tumor
Operated at Johns Hopkins Hospital June 1920
Autopsy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 18-1920

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J. Hoffman Bond M. D.

7/18 1920 (Address) 2044 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid	July 20 1920
20 UNDERTAKER Wm Cook	ADDRESS Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44915

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44915

CERTIFICATE OF DEATH.

15-79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 3844 Bonner Rd. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Shipley

(a) RESIDENCE. No. 3844 Bonner Rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 11, 1845

7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	75	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manager 086

(b) General nature of industry, business, or establishment in which employed (or employer): Sandy Belting Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Powhatan Balto Co Md.

PARENTS

10 NAME OF FATHER Reuben Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Md.

12 MAIDEN NAME OF MOTHER Margaret Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md.

14 Informant John L. Shipley
(Address) 3844 Bonner Rd.

15 Filed JUL 19 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 - 1920

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1920, to July 17, 1920, that I last saw him alive on July 17, 1920, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) P. ? yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Previous examination

(Signed) Dawson J. Barber, M. D.

, 19 (Address) 2303 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 20 1920
20 UNDERTAKER	ADDRESS
George J. Smith	1002 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. FULL NAME should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44916

D44916

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Women Home ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A French

(Residence in Baltimore: No. 1400 W Lexington St.; 20 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Wid

6-DATE OF BIRTH, Aug 21 (Month) (Day), 1834 (Year)

7-AGE, 85 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Harford Co Md

PARENTS.

10-NAME OF FATHER, Wm Green

11-BIRTHPLACE OF FATHER (State or Country), Bel Air Md

12-MAIDEN NAME OF MOTHER Rachel Tomlinson

13-BIRTHPLACE OF MOTHER (State or Country), Harford Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Z Jones

(Address) Matron

15- Filed JUL 19 1920, 191 G. H. Grese. Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1920, to July 16 1920, that I saw h alive on July 16 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(Duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 1 ds.

(Signed) F Norwood M. D.

July 19, 1920 (Address) 739 Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 20 yrs. mos. ds. In the State 85 yrs. mos. ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, July 21, 1920

20-UNDERTAKER Geo J Smith & Son — ADDRESS 1000 Fayette St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44917 ✓ 56 D 44917.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST.: 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William G. McLane

(a) RESIDENCE. NO. Caton Ave & Cedar St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20, 83

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	9	19	

8 OCCUPATION OF DECEASED 089

(a) Trade, profession or particular kind of work Clerk at Gibson

(b) General nature of Industry, business, or establishment in which employed (or employer) grocer store A & Co

(c) Name of employer Mr Gibson

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Asbury McLane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachael Mallonee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Miss Elizabeth McLane
(Address) 505 Patapsco Ave Brooklyn Md

15 Filed JUL 19 1920 G. H. Gresse Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1 1920, to July 5 1920,
that I last saw him alive on July 3 1920,
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Alcoholism

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema Brain

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Geyer M. D.

19 (Address) University Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	July 20 1920
20 UNDERTAKER	ADDRESS
John F Denny	715 Lighter

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 44918

HEALTH DEPARTMENT—CITY OF BALTIMORE

78 D 44918.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 Aisquith ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George M Zimmerman

(a) RESIDENCE. NO. 908 Aisquith ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~ of) Catherine Zimmerman

6 DATE OF BIRTH (month, day, and year) April 17th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
—	65	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet maker

(b) General nature of industry, business, or establishment in which employed (or employer) Penn. R.R. Co

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Kramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas H. Zimmerman
(Address) 908 Augusta St

15 Filed JUL 19 1920 C. H. Grass Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17th 1920

17

I HEREBY CERTIFY, That I attended deceased from June 4th 1920 to July 17th 1920 that I last saw him alive on July 16th 1920 and that death occurred, on the date stated above, at 7.15 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Louis M. C. Oakes, M. D.

19 (Address) 1114 Hollins ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 20th 1920

20 UNDERTAKER ADDRESS

George Schilling + Sons 1126 E Monument st

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D-44919.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-44919

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 903 N. Calhoun ST.; 16 WARD) 47

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Carrie Volker

(Residence in Baltimore: No. 903 N - Calhoun Street St.; 52 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June 28, 1868
(Month) (Day) (Year)

7-AGE, 52 yrs. 1 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 137

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Werner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Sine

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter A Volker

(Address) 903 N. Calhoun St.

15- JUL 19 1920 Baltimore

Filed....., 191..... G. H. Grese
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 16, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 22 1920, to July 16 1920, that I saw her alive on July 14 1920, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus and Liver -

According to Doctor Several Years (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus and Liver (Duration) Several Years mos. ds.

(Signed) Frances A. Carpenter M. D.

July 16, 1920. (Address) 710 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loraine Cemetery — DATE OF BURIAL, July 17, 1920

26-UNDERTAKER Geo. Peterson & Son — ADDRESS 2503 Edmondson Ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D44920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44920

CERTIFICATE OF DEATH (Udrick) 104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 S. Chapel ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stella Udrik

(Residence in Baltimore: No. 415 S. Chapel St.; 2y. yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Sept. 23, 1918.
(Month) (Day) (Year)

7-AGE, 1 yrs. 9 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Albert Udrik

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Berta Wenioska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Udrik

(Address) 415 S. Chapel st.

15- Filed JUL 19 1920, 191..... G. H. Grese. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 18, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 13 1920, to July 15 1920, that I saw h[illegible] alive on July 15 1920, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Intussusception

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Diarrhoea

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) H. L. Simmons M. D.

July 18, 1920. (Address) 722 S. Bond st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	July 19, 1920
20-UNDERTAKER John M. Weber	ADDRESS 1803 Bank st

important. See instructions on back of certificate.

D 44921 HEALTH DEPARTMENT—CITY OF BALTIMORE D 44921

CERTIFICATE OF DEATH.

REGISTERED NO. C 19 26

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1514 W Fairmount ave ST.) 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham Roy

(Residence in Baltimore: No. 1514 W Fairmount ave St.: 1 yrs., 1 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word)
Male	colored	Single

6-DATE OF BIRTH, June (Month) 4 (Day), 1919 (Year)

7-AGE, 1 yrs. 1 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Abraham Roy

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Lena Whipfield

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena Roy

(Address) 1514 W Fairmount ave

15- JUL 19 1920 G. H. Case.

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 18 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suppurated Otitis Media probably involving Mennges

(Duration) ....yrs. 4 mos. ....ds.

CONTRIBUTORY (Secondary) Suppurated Tonsilitis

(Duration) ....yrs. ....mos. ....ds.

(Signed) James M Kuhns M. D.
(Coroner.)

July 19, 1920 (Address) 200 Echaw St

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, July 19, 1920

20-UNDERTAKER A. Jones

ADDRESS 207 S. Stricker St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44922 ✓ 81 D44922

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1926 Port. ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Sargent

(a) RESIDENCE. No. 1926 Port. ST. Sr. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Elizabeth Sargent

6 DATE OF BIRTH (month, day, and year) July 13th 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	0	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Rail Road Loader, 973

(b) General nature of industry, business, or establishment in which employed (or employer) Penna. R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Penna.

PARENTS

10 NAME OF FATHER Geo. Sargent

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Hannah Dalmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Philadelphia Penna

14 Informant (Address) Mrs. Enrico Daughter, 1926 Port St

15 Filed JUL 19 1920 G. H. Grese, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1920

17 I HEREBY CERTIFY, That I attended deceased from July 10 1920 to July 16 1920

that I last saw him alive on July 16 1920

and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of — —

Was there an autopsy? — — —

What test confirmed diagnosis? — — —

(Signed) Geo Clinton Blades M. D.

7/17/20 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 19 1920

20 UNDERTAKER Liston V. Fussellbaugh ADDRESS 620 St Paul

CAUSE OF DEATH in plain terms, so that it may be properly classified. Read carefully the following instructions and the blank form of certificate. IT IS VERY important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D-44923

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-44923

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1322 N Carey ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Polly Ann Savage

(a) RESIDENCE. No. 1322 N Carey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Savage deceased

6 DATE OF BIRTH (month, day, and year) July 10, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic D

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) King & Queen Co
(State or country) Va

PARENTS

10 NAME OF FATHER Armistead Haines

11 BIRTHPLACE OF FATHER (city or town) K & Q Co
(State or country) Va

12 MAIDEN NAME OF MOTHER Maria Collins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) King & Queen Co Va

14 Informant Marguerite Johnson
(Address) 911 Hollins Market St

15 Filed JUL 19 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1920

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1920, to July 15, 1920, that I last saw h alive on July 15, 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes.

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Obesity

(duration) yrs. mos. 22 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Fehling's 6 mos ago

(Signed) William Krueger, M. D.

July 15, 1920 (Address) 1209 Prestman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
U.S. National Cemetery	July 1920

20 UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D44924

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44924

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 N Carrollton ave. ST.: No 120 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary F Smith

(Residence in Baltimore: No. 822 N. Carrollton ave St.; 60 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, Unknown ....., 1..... (Month) (Day) (Year)

7-AGE, ...78.... yrs. ..... mos. ..... da.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Fredericksburg Va

PARENTS.

10-NAME OF FATHER, William England

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Georgiana Gifford

(Address) 822 N. Carrollton ave

15- JUL 19 1920 G. H. Gresc

Filed ..... 191.....

Registrar.

CAUSE OF DEATH. This item must be carefully and correctly answered, as it is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 18 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1st 1920, to July 18 1920, that I saw h[illegible] alive on July 17 1920, and that death occurred, on the date stated above, at 12 AM m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency Hypertrophy

Contributory

about 2 years

(Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) General Dropsy

about 6 months

(Duration) ..... yrs. ..... mos. ..... da.

(Signed) Carter McCoy M. D.

July 21, 1920. (Address) 827 N Carrollton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, July 22 1920

20-UNDERTAKER Chas. G. Black & Son

ADDRESS 1711 W North ave

D44925

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 D44925

1-PLACE OF DEATH

Registered No. C

CITY OF BALTIMORE (No. 1633 Lanvale St. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George A Ford

(Residence in Baltimore: No. ST.: 68 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
m	w	m

6-DATE OF BIRTH Sept. 23rd, 1852 (Month) (Day) (Year)

7-AGE 67 yrs. 9 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Retired 032
(b) General nature of industry, business, or establishment in which employed (or employer) Fireman

9-BIRTHPLACE (State or country) Maryland.

PARENTS

10-NAME OF FATHER George A Ford.

11-BIRTHPLACE OF FATHER (State or country) Maryland.

12-MAIDEN NAME OF MOTHER Julia ?

13-BIRTHPLACE OF MOTHER (State or country) U.S.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Sarah C Ford.

(Address) 1633 N Lanvale St

15. Filed JUL 19 1920 G. H. Grese. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July (Month) 17 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...,

that I saw h... alive on ....., 191...,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

(Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	July 19 1920
20-UNDERTAKER Joseph B Cook	ADDRESS 700 N Bolton St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PARTICULARS must be given as to how long deceased resided at last place of abode, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 44926

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 44926

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1223 Division St. 17 (WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Newby

(Residence in Baltimore: No. 1223 Division St.; 13 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June 13 (Month) (Day), 1885 (Year)

7-AGE, 34 yrs. 8 mos. 3 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Windsor Va

PARENTS.

10-NAME OF FATHER, Wm Brown

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Catherine Courtney

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H Newby

(Address) 1223 Division St

15- Filed JUL 19 1920, 191.... G. H. Gresé Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 18th (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1919, to July 18 1920, that I saw her alive on July 17 1920, and that death occurred, on the date stated above, at 1.40 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) S. E. Hughes M. D.

July 19, 1920 (Address) 1447 Druid Hill Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Sale of Windsor Va DATE OF BURIAL, July 20, 1920

20-UNDERTAKER Chas H Holland ADDRESS 1637 Mercy Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44927

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44927

CERTIFICATE OF DEATH.

142

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth Masco

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed JUL 19 1920 G. H. Greice Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16, 1920

17

I HEREBY CERTIFY, That I attended deceased from April 27, 1920 to July 16, 1920, that I last saw her alive on July 16, 1920, and that death occurred, on the date stated above, at 5:05 P. m.

The CAUSE OF DEATH* was as follows:

Gangrene right leg. unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia
(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. A. Holden, M. D.

7/16/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stephens cemetery	July 21 1920

20 UNDERTAKER Fredricks Sanchaw & Son ADDRESS Fullerton

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44928 (Teresa) **CERTIFICATE OF DEATH.** (Thomas) 28 D44928

1-PLACE OF DEATH REGISTERED NO. C

CITY OF BALTIMORE: (No. 3765 Morley ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Henry Tribby

(Residence in Baltimore: No. 3765 Morley St Yrs. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Jan 14 (Month) Jan (Day) 14 (Year) 1880

7-AGE, 40 yrs. 6 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) House wife

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Sugfried

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Lears

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M. Sugfried

(Address) 3766 Rosalth St

15- JUL 19 1920 G. H. Grese.

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 17 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1918, to July 17 1920, that I saw her alive on July 16 1920, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Howard W Lee M. D.

July 19 1920 (Address) Burlington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, July 20, 1920.

20-UNDERTAKER C. A. Hannon — ADDRESS 1911 W. Lombard St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44929

CERTIFICATE OF DEATH.

109 D 44929

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Hagner

(a) RESIDENCE. No. 643 W. Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widowed

5a If married, widowed, or divorced (or) WIFE of Maggie Hagner.

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Fred Hagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Wesley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mrs. J. H. Dirrp 1119 Poplar Grove St

15 Filed JUL 19 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1920

17 I HEREBY CERTIFY, That I attended deceased from July 16, 20, 19.... to July 16, 1920 that I last saw him alive on July 16, 1920 and that death occurred, on the date stated above, at 3:55 P.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
(Cause - unknown)

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) None

.....(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) ..... M. D.

7/19, 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	July 19 1920

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Fayette

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

Spec.—5-19-15—M. & T.—500 Bks.

Wieneke

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44930

D 44930

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4407 Park Heights Av. ST.; 27 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward W. Wieneke

(Residence in Baltimore: No. 4407 Park Heights Av ST.; 55 yrs. 4 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Divorced

6-DATE OF BIRTH, March (Month) 16 (Day), 1864 (Year)

7-AGE, 56 yrs. 4 mos. 2 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lithographer
(b) General nature of industry, business, or establishment in which employed (or employer): 1063

9-BIRTHPLACE, (State or Country), Balto, Md

PARENTS.

10-NAME OF FATHER, Frederick W Wieneke

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Katherine Wagner

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Frederick D. Wieneke

(Address) 4407 Park Heights Av

15-JUL 19 1920 ROBERT E. KRAUTER

Filed....., 191.... DEPUTY PERMIT CLERK

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 18 (Day), 1920 (Year)

17-I HEREBY CERTIFY, That I attended deceased from June 15 1920, to July 18 1920, that I saw him alive on July 18 1920, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows: (a) Pulmonary Tuberculosis

(b) Laryngeal

(c) Tuberculosis 2

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism

(Duration) yrs. mos. ds.

(Signed) James S. Ashman M. D.

July 19 1920. (Address) 4012 Park Heights

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery

DATE OF BURIAL, July 20, 1920

20-UNDERTAKER Henry Storck & Son

ADDRESS 1351 Eager St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44931 HEALTH DEPARTMENT—CITY OF BALTIMORE D44931

42

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 Redwood ST.: 4 WARD)

2-FULL NAME Mrs Louise Koch

(a) RESIDENCE. NO. 518 Redwood ST., 4 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Koch

6 DATE OF BIRTH (month, day, and year) Oct. 9th 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of Industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Max Koch (Son)
(Address) Overlea Md

15 Filed JUL 19 1920 ROBERT E. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1920

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 19 20, to July 19, 19 20, that I last saw her alive on July 16, 19 20, and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Acute odema of Lungs

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Inoperable Carcinoma of Uterus (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M. L. Lichtenberg, M. D.

7/19, 1920 (Address) 22 W Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	July 21 1920

20 UNDERTAKER Jos Joerdens Son ADDRESS 175 Park

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D44932 D44932 D44932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S.P.H.S.Hosp.No.56, REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Fort McHenry ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest L. Long

(Residence in Baltimore: No. U.S.P.H.S.Hosp.No.56,Ft.McHenry,Md. St.; ..... yrs., 5 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, ... Unknown (Month) ..... Unknown (Day), 1 (Year)

7-AGE,	If LESS than 1 day,
23 yrs. -- mos. -- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Unknown

9-BIRTHPLACE, (State or Country), Florida

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar T. Rosenbrock

(Address) Ft McHenry

15- Filed JUL 19 1920 191.....

ROBERT B KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July (Month) ..... 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 2, 1920, to July 17 1920, that I saw him alive on July 17, 1920, and that death occurred, on the date stated above, at 2.30 AM.

The CAUSE OF DEATH* was as follows:

.....Tuberculosis,chronic pulmonary.....

(Duration) 111111 yrs. 1 mos. 1111 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas R. Payne M. D.

July 17, 1920 (Address) Ft McHenry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? In service

Former or usual residence 403 Fremont ave., Balto, Md.

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, July 22nd 20

20-UNDERTAKER Denel Easton ADDRESS 916 Penna ave

important. See instructions on back of certificate.

Spec.--8-24-14--M. & T.--2000 Bks.

D-44933. HEALTH DEPARTMENT—CITY OF BALTIMORE D44933.

X 1

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S.P.H.S.Hosp.,No.56, REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Fort McHenry ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oswald Olsen

(Residence in Baltimore: No. U.S.P.H.S.Hosp. No.56. St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	Single

6-DATE OF BIRTH, Unknown ---- ---/ (Month) (Day) (Year)

7-AGE, 28 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Seaman 086
(b) General nature of industry, business, or establishment in which employed (or employer)..... Unknown

9-BIRTHPLACE, (State or Country), Norway

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar J. Rademacher

(Address) Ft McHenry

15- FILED JUL 19 1920 ROBERT B KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 17, 1920 (Month) (Day) (Year), 191...

17- I HEREBY CERTIFY, That I attended deceased from July 2 1920, to July 17, 1920, that I saw him alive on July 17, 1920, and that death occurred, on the date stated above, at 7.40 AM

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) ---- yrs. 2 mos. ---- ds.

CONTRIBUTORY (Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) Thomas B. Paynter M. D.

July 17, 1920 (Address) Ft. McHenry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? In service

Former or usual residence 59 Nelson st., Dorchester, Mass.

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL.
St Vincent Cem	July 20, 1920
20-UNDERTAKER	ADDRESS
J. Pierce & Bro	1127 E Balto St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44934 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D44934

D44934 CERTIFICATE OF DEATH. 74

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Brown

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpet Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed JUL 19 1920 ROBERT P. PRUTER Registrar

Burial Permit 17868

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to July 12, 1920, that I last saw him alive on July 11, 1920, and that death occurred, on the date stated above, at 1:00 A.m.

The CAUSE OF DEATH* was as follows: Cerebella Tumor

(duration) 1 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Jan 21-1920

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) George R. Williams M. D.

7/12/ 20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS JUL 19 1920

Commissioner Health.

per Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. (See instructions on back of certificates.)
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L044935 HEALTH DEPARTMENT—CITY OF BALTIMORE L044935

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 17 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William McCrue

(a) RESIDENCE. No. 733 Pennsylvania Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27			

8 OCCUPATION OF DECEASED 045

(a) Trade, profession or particular kind of work Billiard Room-

(b) General nature of indostry, business, or establishment in which employed (or employer) keeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jacksonville, Fla.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed JUL 19 1920 ROBERT I. FEATHER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1920, to July 13, 1920, that I last saw him alive on July 13, 1920, and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 0 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Pool Hall? Baltimore

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum positive

(Signed) Geo. R Wilkinson M. D.

7/14/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Soicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner Health.

JUL 19 1920

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement must be filled in. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44936 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044936

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1210 Towson ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Jacob

(a) RESIDENCE. No. 1210 Towson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of ~~the Wife of~~ Eva Jacob

6 DATE OF BIRTH (month, day, and year) April 3rd 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saloon Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungaria

PARENTS

10 NAME OF FATHER Peter Jacob

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungaria

12 MAIDEN NAME OF MOTHER Rose Tmoha

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungaria

14 Informant Mrs. Eva Jacob (Address) 1200 Towson St.

15 Filed JUL 19 1920 ROBERT B [illegible] Registrar

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1920, to July 17th, 1920, that I last saw him alive on July 17th, 1920, and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (?)

approximately (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio-Vascular disease, unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of April 25th 20

Was there an autopsy? no.

What test confirmed diagnosis? Physical symptoms & Exam-

(Signed) Bruce H. Jones, M. D.

, 19 (Address) 1206 W. Walker.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. Q.A.	July 20 1920
20 UNDERTAKER M. J. Flynn	ADDRESS 1432 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

1044937

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044937

CERTIFICATE OF DEATH.

K 40

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 112 N. 24th St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 16.)

2-FULL NAME Maria J. Edwards.

(Residence in Baltimore: No. 112 N. 24th St.; ... yrs. 3 mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Aug. (Month) 5 (Day), 1850 (Year)

7-AGE.	If LESS than 1 day,
70 yrs. 11 mos. 14 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of Industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Halifax Co, Va.

PARENTS.

10-NAME OF FATHER, Wm J. Powell.

11-BIRTHPLACE OF FATHER (State or Country), Halifax Co, Va.

12-MAIDEN NAME OF MOTHER Elizabeth Carter.

13-BIRTHPLACE OF MOTHER (State or Country), Halifax Co, Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. E. Burton

(Address) Richmond, Va.

15- Filed JUL 19 1920, 191... ROBERT B. KRAUTER, Registrar.

CAUSE OF DEATH must be filled in by the attending physician. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 19 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 23 1920, to July 18, 1920, that I saw h[illegible] alive on July 18, 1920, and that death occurred, on the date stated above, at 10.45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus
(Cancer of Stomach)

(Duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Haigh Forsythe M. D.

July 19, 1920. (Address) 121 E. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.

Where was disease contracted, if not at place of death? Duffau Texas

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Duffau Texas — DATE OF BURIAL, July 20, 1920

20-UNDERTAKER E. A. Winfield Jr. — ADDRESS 2013 Grace Ave

Spec.—8-24-14—M. & T.—2000 Bks.

1044938 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044938

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 335 E 22nd St ST.; 12 WARD) REGISTERED No. C

2-FULL NAME Laura Harryman

(Residence in Baltimore: No. 335 E 22nd St St. Life yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, December 11 (Month) (Day), 1855 (Year)

7-AGE, 64 yrs. 10 mos. 6 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Mitchell

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Caroline LaRue

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. D. Harryman

(Address) 335 E 22nd St

15- Filed JUL 19 1920, 191... ROBERT E. KRAUTER REGISTRAR Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 11 1920, to July 17 1920, that I saw her alive on July 17 1920, and that death occurred, on the date stated above, at 1:45 P.M.

The CAUSE OF DEATH* was as follows:

Edema of Laryngeal Tissues

Phthisis

Mitral Regurgitation

(Duration) 11 yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) Geo. Burgess M.D. M. D.

July 18, 1920 (Address) 4016 E 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, July 20, 1920

20-UNDERTAKER E. A. Wiedefeld — ADDRESS Eutaw St

CAUSE OF DEATH to be plainly written in ink. Every question must be answered if possible. Do not leave any blanks except when directed to do so. Every certificate must be signed. Every statement should be full and complete. Every item is important. See instructions on back of certificate.

Spec.—6-8-19—H. P. Co.—1000 Bks.

D44939 HEALTH DEPARTMENT—CITY OF BALTIMORE D44939

CERTIFICATE OF DEATH. 61

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Donald Byers

(a) RESIDENCE. No. 643 Pulaski St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Oct 19 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James H Byers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sadie Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address) [illegible]

15 Filed JUL 19 1920 19 ROBERT J. LEATHER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1920

17

I HEREBY CERTIFY, That I attended deceased from July 17 1920 to July 18 1920 that I last saw h[illegible] alive on July 18 1920 and that death occurred, on the data stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

acute meningitis (B. influenza)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) ~~Date~~ Brain abscess (duration) 2 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Pts home

Did an operation precede death? Trephine Date of 7/17/20

Was there an autopsy? Yes

What test confirmed diagnosis? culture & smear

(Signed) W M Tapp, M. D.

, 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	July 21 1920
20 UNDERTAKER	ADDRESS
E. A. Woodfield Jr	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. State whether DEATH was from Violence, Suicide or Homicide. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44940 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 78 D44940

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 6 E Fort Ave ST.: 23 WARD)
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Morris

(a) RESIDENCE. NO. 6 E Fort Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wilbur Morris

6 DATE OF BIRTH (month, day, and year): Feb 20 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	4	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): at home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington Co Md

PARENTS
10 NAME OF FATHER: Samuel Creager
11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington Co Md
12 MAIDEN NAME OF MOTHER: Annie Walker
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington Co Md

14 Informant: Samuel Walker
(Address): 6 E Fort Ave

15 FILED JUL 19 1920 ROBERT B. LEAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Apr 2 1920, to July 19 1920.
that I last saw her alive on July 19 1920.
and that death occurred, on the date stated above, at 3 p m.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Same
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical
(Signed) Wm E Stifler M. D.
7/9 1920 (Address) 139 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hagerstown Md	7/20 1920
20 UNDERTAKER	ADDRESS
Mrs J. E. Grandle	148 E Mkt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-24-14—M. & T.—2000 Bks.

D 44941

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 44941

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125. Hull. ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Majewski

(Residence in Baltimore: No. 1125 Hull St.; ....yrs., 7 mos. 11 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Dec (Month) 7 (Day), 1919 (Year)

7-AGE, ...yrs. 7 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Now pod
(b) General nature of industry, business, or establishment in which employed (or employer): " "

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Stanislaw Majewski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Frances Bupczyk

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) St. Majewski

(Address) 1120 Hull

15- JUL 20 1920 G. H. Grese.

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7 (Month) 18 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 7-12- 1920, to 7-18- 1920, that I saw him alive on 7-17- 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Pyloric Stenosis

(Duration) ....yrs. ....mos. 3 ds.

(Signed) H. Brosh M. D.

7-19- 1920 (Address) 1520 Fort Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Holy Rosary

DATE OF BURIAL. July 20, 1920

20-UNDERTAKER Wm Gallowski

ADDRESS 1618 Ess

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 44942 HEALTH DEPARTMENT—CITY OF BALTIMORE 1/2 44942

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 815 Eastern Ave ST.: 3 WARD)

2-FULL NAME Catherine M. Crovo

(a) RESIDENCE. NO. 815 Eastern Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Crovo

6 DATE OF BIRTH (month, day, and year): May 4 1835

7 AGE — Years: 85 — Months: 2 — Days: 15 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Bartholmew Crovo

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Mary Crovo

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: John Crovo
(Address): 815 Eastern Ave

15 Filed JUL 20 1920 19 G. H. Cresse Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19 19 20

17 I HEREBY CERTIFY, That I attended deceased from July 10, 19 20, to July 19, 19 20, that I last saw h[illegible] alive on July 19, 19 20, and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Senile Debility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) J. Wenton, M. D.

July 20, 19 20 (Address) 1165 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents — DATE OF BURIAL: July 21 19 20

20 UNDERTAKER: Kendall Dippel & Son — ADDRESS: 37 [illegible] St

Spec.—8-24-14—M. & T.—2000 Bks.

D 44943

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 44943

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH Womans Hospital 13 REGISTERED NO. C.....

CITY OF BALTIMORE: (No..... ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Shane Hilda Levinsohn

(Residence in Baltimore: No. 2436 Madison Ave St.; 18 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Married

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1857 (Year)

7-AGE, 63 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or Country) Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nathan Levinsohn

(Address) 2436 Madison Ave

15- JUL 20 1920 G. H. Grese.

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 19 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 10 1920, to July 19 1920, that I saw her alive on July 19 1920, and that death occurred, on the date stated above, at 2 30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma head of pancreas

..... (Duration) .....yrs. 6 mos. .....ds.

CONTRIBUTORY (Secondary) Operation: Cholecystostomy Drainage (Duration) .....yrs. 1 mos. 7 ds.

(Signed) James L. Speed M. D.

July 21, 1920 (Address) Womans Hospt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. 1 mos. 10 ds. In the State 18 yrs. — mos. — ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 2436 Madison Ave,

19-PLACE OF BURIAL OR REMOVAL, Sherwood Southern Cem

DATE OF BURIAL, July 20, 1920

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balt

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

D 44944

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44944

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 646 E. 28. St. 9 WARD)

REGISTERED No. C 8

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Elizabeth Johnson

(Residence in Baltimore: No. 646 E. 28 St, St.; yrs. 1yr mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem'l

4-COLOR OR RACE: Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Mary

6-DATE OF BIRTH: Aug 22, 1919.
(Month) (Day) (Year)

7-AGE: ..yrs. 10 mos. ..ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: John Johnson

11-BIRTHPLACE OF FATHER (State or Country): Va

12-MAIDEN NAME OF MOTHER: Annie Green

13-BIRTHPLACE OF MOTHER (State or Country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Johnson

(Address) 646 E 28 St

15- JUL 20 1920 G. H. Grese.

Filed ....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Jan 18, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest, aforesaid that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

a Pneumonia 6

(Duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(Duration) ..yrs. ..mos. ..ds.

(Signed) [illegible] (Coroner)

1-28, 1920 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: St Peters Cemetery

DATE OF BURIAL: JUL 20 1920

20-UNDERTAKER: R E Grove

ADDRESS: 1405 McElderry St

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 44945

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44945

CERTIFICATE OF DEATH.

6 117

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Metzler

(a) RESIDENCE. No. 2609 E. Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 24/1878 July 24, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Mark J. H. Metzler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Butler Ann E.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ona Hagie

(Address) 2609 E. Fayette

15 Filed JUL 20 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1920

17 I HEREBY CERTIFY, That I attended deceased from July 7 . 1920 . to July 17 . 1920.

that I last saw him alive on July 17 . 1920.

and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of July 8, 1920

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Byron S. Hamill . M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 21 1920

20 UNDERTAKER Jos. J. Herr ADDRESS 15 E. Lanvale ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44946

HEALTH DEPARTMENT—CITY OF BALTIMORE D44946

D44946

CERTIFICATE OF DEATH.

REGISTERED NO. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 4330 Eastern Ave ST.; 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Stabile

(a) RESIDENCE. NO. 4330 Eastern Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 16-1919.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Stanislaus Stabile

11 BIRTHPLACE OF FATHER (city or town) (State or country) Naples Italy

12 MAIDEN NAME OF MOTHER Mary Trotta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Naples Italy

14 Informant (Address) Stanislaus Stabile 4330 Eastern Ave

15 FILED JUL 20 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1920

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1920, to July 18, 1920, that I last saw h.. alive on July 18, 1920, and that death occurred, on the date stated above, at 2.56 m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M. J. Mahoney, M. D.

7/19 1920 (Address) 834 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patricks Cem.	July 20 1920
20 UNDERTAKER Lilly & Feiler	ADDRESS 403 W Fay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 44947

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 44947

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 344 S. Clinton St.: W. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Howard Moore

(a) RESIDENCE. No. 344 S. Clinton St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 3-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Samuel A. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Albina Waese.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alsace Lorraine Germany

14 Informant (Address) Samuel A. Moore 344 S. Clinton St.

15 Filed JUL 20 1920 C. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1920

17 I HEREBY CERTIFY, That I attended deceased from July 17 1920 to July 17 1920 that I last saw him alive on July 17 1920 and that death occurred, on the date stated above at 8 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Leo. Heller, M. D.

19 (Address) 1937 Druid St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	July 20 1920
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MODE OF DEATH is very important. See instructions on back of certificates.

D 44948

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 44948

1202

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 216 S. Chapel ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter J Kane

(Residence in Baltimore: No. 216 S Chapel St.; 1yo yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb 28, 1850 (Month) (Day) (Year)

7-AGE, 70 yrs. 4 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer) O&T

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, John Keene

11-BIRTHPLACE OF FATHER (State or Country) Germany.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Keene

(Address) 216 S. Chapel

15- JUL 20 1920 G. H. Grese.

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 18, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to h.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Henry Spain Forsyth M. D. (Coroner)

July 19, 1920. (Address) 1610 E Baltr St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, St Patrick Cem. DATE OF BURIAL, July 21, 1920.

20-UNDERTAKER McCole ADDRESS 502 E Nath

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in every case. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D44949

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44949

CERTIFICATE OF DEATH.

1-PLACE OF DEATH ~~Lombard 1548~~

CITY OF BALTIMORE (No. ~~2465 High~~ 3 St.: 79 WARD) REGISTERED No. C

2-FULL NAME Chas L Smith

(Residence in Baltimore: No. 310 S Wolfe St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: (yrs., 57 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, About 54 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION.
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Benj E Smith

11-BIRTHPLACE OF FATHER (State or Country) Md

12-MAIDEN NAME OF MOTHER Elizabeth Hayward

13-BIRTHPLACE OF MOTHER (State or Country), West Indies

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary V Smith

(Address) 5464 Park Heights Av

15- Filed JUL 20 1920 191 G. H. Cresse Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 18, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest and
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
Medical Aid find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chester Sigler Cassady M. D.
(Coroner)
June 19, 1920 (Address) 310 S Wolfe St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cem — DATE OF BURIAL, July 20, 1920

20-UNDERTAKER W E Pickens & Co — ADDRESS Park Ave

3.—Every item of information should be carefully supplied. Any item not properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Inf of Thos F & Mamie M. Kreiner

D44950

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44950

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1902 Wallbrook Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME (unnamed) male child.

(Residence in Baltimore: No. 1902 Wallbrook Ave St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	Single

6-DATE OF BIRTH, July (Month) 18 (Day), 1920 (Year)

7-AGE, ——yrs. ——mos. ——da. If LESS than 1 day, 8 hrs. or 18 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Thomas Frederick Kreiner Jr.

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Mamie Mildred Bradley

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas F. Kreiner Jr.

(Address) 1902 Wallbrook Ave.

15- JUL 20 1920 G. H. Grese.

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 19 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 18 1920, to July 19 1920, that I saw h[illegible] alive on July 18 1920, and that death occurred, on the date stated above, at 6.30 p.m.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) —yrs. —mos. —da.

CONTRIBUTORY (Secondary) none

(Duration) —yrs. —mos. —da.

(Signed) Chester Reland M. D.

7-19—, 1920 (Address) 2532 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, July 20, 1920

20-UNDERTAKER Wm J Tickner Son ADDRESS N. Y Pa

CAUSE OF DEATH must be properly entered. Each statement is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D44951 HEALTH DEPARTMENT—CITY OF BALTIMORE D44951

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....

(Residence in Baltimore: No. Catherine M. Hohman St.; Life yrs.. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, ~~WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 72 yrs. \ mos. \ ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER. Francis Hohman

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Elizabeth Horning

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15- JUL 20 1920 G. H. Grese.

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19th, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191 ..., to ..... 191 ..., that I saw h Er alive on July 18 1920, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

2 mos. (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Warner M. D.

July 19 1920, Address (Address) 1133 Vaughan St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 70 yrs. 1 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, July 20, 1920.

20-UNDERTAKER H. C. Wadefeld — ADDRESS 914 Gremont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Care and attention of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 44952

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44952

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.: 7 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Lehman

(a) RESIDENCE. No. 811 N Kenwood Ave St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Uriel D Lehman

6 DATE OF BIRTH (month, day, and year): Sept 12 1848

7 AGE: ~~72~~ Years 71 Months 10 Days 7 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Indiana

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Indiana

14 Informant: Miss Selma Lehman (Address) 811 N. Kenwood Ave

15 Filed JUL 20 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July, 19 1920

17 I HEREBY CERTIFY, That I attended deceased from July, 19, 1920, to July, 19, 1920 that I last saw her alive on July, 19, 1920 and that death occurred, on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction.

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary): Cardiac Dilatation

(duration) Unknown ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July, 1920

Was there an autopsy? ...

What test confirmed diagnosis? Clinical Findings

(Signed) Frank Lee M.D.

7/9, 19 20 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	July 21 1920
20 UNDERTAKER	**ADDRESS**
Harry Sondheim	1018 W. Lexington

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 4 4953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1d D 44953

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1503 E. Monument ST.; 7 WARD.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edmund Liggins

(Residence in Baltimore: No. 1503 E. Monument St., 40 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widower

6-DATE OF BIRTH, Feb. (Month) 14 (Day), 1879 (Year)

7-AGE, 61 yrs. 5 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Richmond, Va.

PARENTS.

10-NAME OF FATHER, Daniel Liggins

11-BIRTHPLACE OF FATHER (State or Country) Richmond, Va.

12-MAIDEN NAME OF MOTHER Eastman

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Cox

(Address) 1503 E. Monument St

15-

Filed JUL 20 1920, 191.... G. H. Grese. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11 June 1920, to 17 July 1920, that I saw h[illegible] alive on 16 July 1920, and that death occurred, on the date stated above, at 4.40 a.m.

The CAUSE OF DEATH* was as follows:

Senility Bronchitis, Etc

About five years

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac arterio sclerosis

about two weeks

(Duration) yrs. mos. ds.

(Signed) Ellwyn Hoyle M. D.

1877, 1920 (Address) 47 W. Madison St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury

DATE OF BURIAL, July 26 1920

20-UNDERTAKER John W Henderson

ADDRESS 1502 E Mon[illegible]t

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D44954 D44954

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 Lanvale ST.; 17 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert Dorsey

(Residence in Baltimore: No. 612 Lanvale St.: 1 yrs., 1 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, June 10, 1919
(Month) (Day) (Year)

7-AGE, ...yrs. ...mos. ...ds. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country) 211 S Dallas St Balto Md.

PARENTS.

10-NAME OF FATHER, Robert Dorsey

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Mabel Brandon

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mabel Dorsey

(Address) 612 W. Lanvale St.

15- Filed JUL 20 1920, 191... G. H. Grese. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 12th 1920, to July 19th 1920, that I saw h[illegible] alive on July 12th 1920, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis ORV
(Middle or Inferior Lobe)

(Duration) ...yrs. 1 mos. ...ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ...yrs. 1/2 mos. ...ds.

(Signed) Russell Legg M. D.

July 19, 1920 (Address) 516 S Bethel St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel	July 21, 1920
20-UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Date statement of cause is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44955

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44955

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 22 S. Regester ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Dodd

(a) RESIDENCE. No. 22 S. Regester ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook or 1

(b) General nature of industry, business, or establishment in which employed (or employer) no

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) md-

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Annie Fleet

(Address) 22 S Regester st

15 Filed JUL 20 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1920, to July 18, 1920, that I last saw her alive on July 18, 1920, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Senile debility

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. C. Robins, M. D.

7/19/20 (Address) 1520 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion	July 21 1920

20 UNDERTAKER John W Henderson ADDRESS 1503 E Monument

mation should be carefully supplied. All the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44956 ✓ D44956

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

55

1-PLACE OF DEATH South Balto Gen. Hos. 23 REGISTERED NO.

CITY OF BALTIMORE: (No. 1213 Light St.) ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elsie Eberlein

(a) RESIDENCE. NO. 16 E Randall St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Eberlein

6 DATE OF BIRTH (month, day, and year) Jan 3rd 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
22	21	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 637

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER L. Christian Groat

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Matilda Gordon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant William Eberlein
(Address) 16 E Randall St

15 Filed JUL 20 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1920

17 I HEREBY CERTIFY, That I attended deceased from July 7 1920 to July 19 1920, that I last saw her alive on July 19 1920, and that death occurred, on the date stated above, at 2.50 m.

The CAUSE OF DEATH* was as follows:

Puerperal hemorrhagica.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. C. Dohihel. M. D.

19 (Address) S. Balto Gen. Hos.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	July 21 19
20 UNDERTAKER	ADDRESS
D Schlosman & Son	Fairmont Av

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPA-
it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44957

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44957

105

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 304 E Hamburg ST. 24 WARD)

2-FULL NAME Mary F. Cleary

(a) RESIDENCE. NO. 364 E Hamburg ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: James P. Cleary

6 DATE OF BIRTH (month, day, and year): Apr 8 1865

7 AGE: Years 55 Months 3 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): ——

(c) Name of employer: ——

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: James Leahy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Julia Poole

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Miss Marie Sugars 304 E. Hamburg St.

15 Filed JUL 20 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19th 1920

17 I HEREBY CERTIFY, That I attended deceased from March 26 1920 to July 19 1920.

that I last saw h— alive on July 18 1920.

and that death occurred, on the date stated above, at 2. A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. 8 hrs.

CONTRIBUTORY (Secondary): Chronic Gastro Enteritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. M. Mackie M. D.

July 19 1920 (Address) 1277 Hillman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cemetry — DATE OF BURIAL: 7/22/20

20 UNDERTAKER: F A Krause & Son — ADDRESS: 763 Hanover

mation should be carefully supplied. AGE should be stated correctly. Exact statement of OCCUPA-
it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
on back of certificates. TION is very important. See instructions on back of certificates.

D44958 HEALTH DEPARTMENT—CITY OF BALTIMORE D44958

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 310 S. Stirson ST.: 20 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Glatthaar

(Residence in Baltimore: No. 310 S. Stirson St.; yrs. 64 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Mal	Wht	Married

6-DATE OF BIRTH, Sept (Month) 3 (Day), 1870 (Year)

7-AGE, 49 yrs. 10 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: 931
(a) Trade, profession, or particular kind of work: machine hand
(b) General nature of industry, business, or establishment in which employed (or employer): S & D Chemicals

9-BIRTHPLACE, (State or Country), Balto City.

PARENTS.

10-NAME OF FATHER, Peter Glatthaar

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Glatthaar

(Address) 310 S Stirson St

15-

Filed JUL 20 1920 G. H. Grese.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 18 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. 4 hrs.

CONTRIBUTORY (Secondary) Arterio sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James H. Fenton M. D.
(Coroner.)

July 19 1920 (Address) 700 E. Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cemetery	July 20 1920
20-UNDERTAKER	ADDRESS
F. W. Shipley	2236 Frederick Ave

N. B.—Every item of information should be carefully supplied. AGE should be given EXACTLY. PHYSICIAN should properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 44495 9

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 44495 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1936 Mt Royal Terrace ST., 13 WARD)

2-FULL NAME Elizabeth Dunbar Richards

(a) RESIDENCE. NO. 1936 Mt Royal Terrace ST., WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 92 yrs. 9 mos. 19 ds.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Richards

6 DATE OF BIRTH (month, day, and year) Oct-1-1827

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	92	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 00

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Pittsfield
(State or country) Massachusetts

PARENTS

10 NAME OF FATHER John Dunbar

11 BIRTHPLACE OF FATHER (city or town) ? ?
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Ann Delmage

13 BIRTHPLACE OF MOTHER (city or town) ? ?
(State or country) Scotland

14 Informant (Mrs. A. M. Kinsman) (Daughter)
(Address) 1936 Mt Royal Terrace.

15 Filed JUL 20 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-19-1920.

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1920. to July 19, 1920.
that I last saw her alive on July 19, 1920.
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: OVER

Chronic Nephritis,

(duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Senility,
(duration) ? yrs. ? mos. ? da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) Maurice L. Shamm, M. D

7/19, 1920 (Address) 3300 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spaces.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Amboy-Lee Co-Illinois	July 21 1920.
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Supt.)	ADDRESS 108 W. NORTH AVE.

mation should be carefully supplied. Age and
it may be properly classified. Exact statement of
CUPA
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on b
on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 44960

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44960

CERTIFICATE OF DEATH.

X 105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Theodor Zimmerman

(a) RESIDENCE. No. Waterbury Conn. ST., WARD. Waterbury Conn.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Feby 7th 1861

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
abt	59	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rev. Clergyman 018

(b) General nature of Industry, business, or establishment in which employed (or employer) Church work -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Retreat -

15 Filed JUL 20 1920 19 G. H. Gresse Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 19

17 I HEREBY CERTIFY, That I attended deceased from July 7th, 1920, to July 19, 19..., that I last saw h.. alive on July 19, 19..., and that death occurred, on the date stated above, at 11:45 a. m.

The CAUSE OF DEATH* was as follows:

Gastro - Entero - Colitis -

(duration) 0 yrs. 0 mos. 21 ds.

CONTRIBUTORY (Secondary) Dementia

(duration) 0 yrs. 0 mos. 21 ds.

18 Where was disease contracted if not at place of death? Waterbury Conn -

Did an operation precede death? NO Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. F. Cannery, M. D.

July, 19 (Address) Mount Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Britain - Conn. DATE OF BURIAL July 20 1920

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) ADDRESS 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. If LESS than a day or a year, the fraction of a day or year at it may be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D44961 HEALTH DEPARTMENT—CITY OF BALTIMORE D44961

CERTIFICATE OF DEATH.

80

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 530 n ~~Fremont~~ Lamsdale ST.; WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard C. Miller

(Residence in Baltimore: No. 530 n Lemwood Ave St.; yrs., 44 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Widower

6-DATE OF BIRTH, June (Month) 14 (Day), 1875 (Year)

7-AGE, 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) 066

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John J Miller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Marie Littmann

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie J Miller

(Address) 530 N. Lemwood Ave

15- JUL 20 1920 G. H. Grese

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 18 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J Wirt Bowles M.D. (Coroner.)

....., 191... (Address) 4 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, ~~OR REMOVAL,~~ — DATE OF BURIAL, Woodlawn Cem July 21, 1920

20-UNDERTAKER Wm J Tuckner & Son ADDRESS 117 Pa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If UNDER 1 YEAR or OVER 100 YEARS, the EXACT AGE in years, months and days should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

1044962 HEALTH DEPARTMENT—CITY OF BALTIMORE 1044962

CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5003 O. Donnell St. 26 WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary K. Debelius.

(a) RESIDENCE. No. 5003 O'Donnell ST. 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of the late Henry Debelius.

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Gobelein.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Margaret Schield.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Margaret Schott
(Address) 5003 O. Donnell St.

15 Filed JUL 20 1920 ROBERT E. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18th 1920

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1920, to July 18, 1920, that I last saw her alive on July 16, 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver & Intestines

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Harvey Tilden, M. D.

7/20, 1920 (Address) 2721 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	July 21st 1920
20 UNDERTAKER	ADDRESS
Lilly-Zeiler	403 S. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-17—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1420 44963. 44963.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp. ST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Ennalls

(a) RESIDENCE. No. 8 N. Caroline St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): April 8 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of Industry, business, or establishment in which employed (or employer): 000

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm Ennalls

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Daisy Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Record
(Address): J 16 26

15 Filed JUL 20 1920 ROBERT S. LEATHERBURY Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19 1920

17

I HEREBY CERTIFY, That I attended deceased from July 17, 1920, to July 19, 1920, that I last saw h[illegible] alive on July 19, 1920, and that death occurred, on the date stated above, at 11 00 P. m.

The CAUSE OF DEATH* was as follows:

acidosis (renal insufficiency)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): chron nephritis

(duration) yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Coleman

(Signed) [signature], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sabury Conn.	July 21st 1920

20 UNDERTAKER: Harry A Lodery ADDRESS: 1725 Eutaw St

mation should be carefully supplied. Age CAUSE OF DEATH in plain terms; so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-1—H. P. Co.—1000 Bks.

1482 31 D44964

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44964

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (ST.) 2 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin F. Male

(a) RESIDENCE. (No.) 1836 Gough St. (ST.) (WARD.)
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Male

6 DATE OF BIRTH (month, day, and year): Sept 28-1853

7 AGE: 67 Years 9 Months 26 Days

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cooper 086

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Wm. H. Male

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Ridgley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Hospital Record
(Address) City

15 Filed JUL 20 1920 19 ROBERT J. BRADY Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19 1920

17 I HEREBY CERTIFY, That I attended deceased from July 12. 1920 to July 19 1920, that I last saw him alive on July 19 1920, and that death occurred, on the date stated above, at 12-0 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes No Date of 7/19/20

Was there an autopsy?

What test confirmed diagnosis? Usual W. tests

(Signed) Wm Nachlas M. D.

, 19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: July 22 1920

20 UNDERTAKER: Williams Cook

ADDRESS: 502 E North Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

id 44965- HEALTH DEPARTMENT—CITY OF BALTIMORE V 44965-

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (NO. 2029 Eden ST.; 2 WARD)

2-FULL NAME Anton Krawczyk (KRAWCZYK)

(Residence in Baltimore: No. 2029 Fleet St.; ...yrs., ...mos., ...da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.) 1 floor

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, July 20, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. ...mos. ...da.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ...
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Anton Krawczyk

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Julia Chesnok

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antoni Krawczyk

(Address) 2029 Fleet St.

15-

Filed AUG 20 1920, 191... ROBERT P. KRAUTER Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 20, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 2 1920, to July 20 1920, that I saw h— alive on July 20 1920, and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

8 hrs

(Duration) ...yrs. ...mos. ...da.

CONTRIBUTORY (Secondary) ...

(Duration) ...yrs. ...mos. ...da.

(Signed) E. Wareham M. D.

July 20, 1920. (Address) 116 S. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...da. In the State ...yrs. ...mos. ...da.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, July 21, 1920

20-UNDERTAKER William Fiszkowski — ADDRESS 148 Eastern Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44966 HEALTH DEPARTMENT—CITY OF BALTIMORE D44966

CERTIFICATE OF DEATH. 19

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 Reservoir ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isidor Blondheim

(a) RESIDENCE. No. 808 Reservoir ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 26/1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing 045

(b) General nature of industry, business, or establishment in which employed (or employer) Mnfg.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Solomon Blondheim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Pauline [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant I Blondheim (Address) 808 Reservoir

15 Filed JUL 20 1920 19 ROBERT E. SLAUTER Registrar

Burial Permit Given

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19th 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept. 24' 19'9. to July 19' 1920.

that I last saw h[illegible] alive on July 19' 1920.

and that death occurred, on the date stated above, at 7 15 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) — yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? — No

What test confirmed diagnosis? Blood Examination

(Signed) Louis P. Hamburger, M. D.

July 20 1920 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew	July 21 1920

20 UNDERTAKER Harris Sondheim ADDRESS [illegible]

Spec. 6-9-19—H. P. Co.—1000 Blks.

644967 HEALTH DEPARTMENT—CITY OF BALTIMORE 644967

CERTIFICATE OF DEATH. 69

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. Hamilton Ave. near Gilmor St.; Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Leo. Beckman

(a) RESIDENCE. No. Hamilton Ave. near Greenspring Ave. ST., WARD. 27th Ward

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2yr. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 15th 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Silver Smith Chaser

(b) General nature of industry, business, or establishment in which employed (or employer) 838

(c) Name of employer Stieff & Co. Baltimore Maryland

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Gouse Beckman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany Germany

12 MAIDEN NAME OF MOTHER Augusta Gore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland

14 Informant Mrs. Augusta Beckman (Address) Ruxton Md.

15 Filed JUL 20 1920 19 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19th 1920

17

I HEREBY CERTIFY, That I attended deceased from July 18 . 1920 . to July 19 . 1920

that I last saw him alive on July 18 1920 .

and that death occurred, on the date stated above, at 6 15 a. m.

The CAUSE OF DEATH* was as follows:

Epilepsy

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

7/20. 1920 (Address) Ruxton, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 22 1920

20 UNDERTAKER Fredk Lassahn & Sons ADDRESS Fulton Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1923 1044968

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044968

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.; 17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd P. Jones

(a) RESIDENCE. No. 149 Penn Ave Atlanta St., Ga Ward. Atlanta Ga

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) April 7-1920

7 AGE Years 3 Months 12 Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER J. S. Jones Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Macon, Ga

12 MAIDEN NAME OF MOTHER Eliz. Parks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Atlanta, Ga.

14 Informant Hospital Record (Address) J. H. H.

15 Filed JUL 20 1920 19 ROBERT S. ERAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1920

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1920, to July 19, 1920, that I last saw h.... alive on July 19, 1920, and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus –

(duration) yrs. 3 mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? Yes Date of July 15, 20

Was there an autopsy? Yes –

What test confirmed diagnosis? Operation

(Signed) Mont R. Reid, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Atlanta Ga	July 22
20 UNDERTAKER	ADDRESS
H. E. Hughes	Broadway

MATTER SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1944969

HEALTH DEPARTMENT—CITY OF BALTIMORE

1944969

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2542 Eager Pl. ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Giovanni Matani

(a) RESIDENCE. No. 2542 Eager Place ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs / mos. / ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 8-1904

7 AGE 15 Years 9 Months 11 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Mose Matani

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Carmela Tritone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mose Matani
(Address) 2542 Eager Place

15 JUL 20 1920 Filed ..., 19.. ROBERT P. LAZENBY Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19th 1920

17 I HEREBY CERTIFY, That I attended deceased from 7-6-, 1920, to 7-19-, 1920.

that I last saw h[illegible] alive on 7-18-, 1920

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary T. B.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? State Sanitorium

(Signed) S. D'Amaro, M. D.

, 19 (Address) 1604 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	7/21 1920

20 UNDERTAKER — ADDRESS

George J Ruth — 1735 Hoffman Lane

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44970

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 D44970

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1122 N Gilmor ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Meeth.

(a) RESIDENCE. No. 1122 N Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Meeth.

6 DATE OF BIRTH (month, day, and year) December 18 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Elementary Teacher.

(b) General nature of industry, business, or establishment in which employed (or employer) — 068

(c) Name of employer Dept of Education of Balto City

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Nicholas Meeth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna M. Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Meeth. (Address) 1122 N Gilmor St

15 Filed JUL 21 19.. G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1920

17 I HEREBY CERTIFY, That I attended deceased from July 15 1920, to July 19 1920, that I last saw him alive on July 18 1920, and that death occurred, on the date stated above, at 6.50 A m.

The CAUSE OF DEATH* was as follows:

OTEN

Acute Nephritis

(duration) .... yrs. .... mos. 4 ds.

CONTRIBUTORY (Secondary) .... (duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Evaporation of urine

(Signed) Henry M. Thomson, M. D.

1920 (Address) 1022 West Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Pauls. Cem Dulaneyville	July 21 1920

20 UNDERTAKER A Rohde & Son. ADDRESS 60 Herlington Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D44971

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 108 D44971

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST.: 4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew S. Arrington

(a) RESIDENCE. No. Laurel, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. L. Arrington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Frothingham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Hospital Record.
(Address)

15 Filed ..., 19 JUL 21 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1920

17

I HEREBY CERTIFY, That I attended deceased from July 3, 1920, to July 21, 1920, that I last saw him alive on July 20, 1920, and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Emphysema

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of July 20, 1920

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Harry E. Stein, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md.	July 21 1920

20 UNDERTAKER	ADDRESS
E & B Hale	115 E West St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co – 1000 Bks.

D44972

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44972

105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225-2 Druid St.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Tikkerakye

(a) RESIDENCE. No. 225-2 High St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Feb 20 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7.	8.	20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child at ...

(b) General nature of industry, business, or establishment in which employed (or employer) ... School

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Lenard Penn

PARENTS

10 NAME OF FATHER George Tikkerakye

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia Poland

12 MAIDEN NAME OF MOTHER Katherine Kaufeld

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore County

14 Informant ... (Address) 225-2 Druid St

15 Filed JUL 21 1920 G. H. Creed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1920

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1920, to July 20, 1920, that I last saw h. alive on ... 20, 1920, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: 0032

Acute Dysentery

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) ...

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Shenandoah, Pa

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? ...

(Signed) J. Weinstein, M. D.

(Address) 16 W Berry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	June 19 20
20 UNDERTAKER	ADDRESS
Randall Bros	1 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42 12 244973 — X 150 244973

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Turnbull

(a) RESIDENCE. NO. 61 Kinsley Rd. St Helena, Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): May 29-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	/	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child 800

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Edw. Turnbull

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Mary Draus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Hospital Record J.H.H.

15 Filed JUL 21 1920 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19 1920

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1920, to July 19, 1920, that I last saw h[illegible] alive on July 19, 1920, and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

Hypertrophic stenosis of pylorus.

(duration) yrs. Birth mos. ds.

CONTRIBUTORY (Secondary): Malnutrition

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Pathology

(Signed) Wm Taylor M. D.

, 19 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	July 21 1920
20 UNDERTAKER	ADDRESS
J Herwig & Co	2008 Eden

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' supplies may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D44974

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44974

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hebrew Hospital St. 20 WARD) 186

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Union

(Residence in Baltimore: No. 2105 Eagle Street St. 7 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: Unknown, 1892
(Month) (Day) (Year)

7-AGE: 28 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Upholsterer
(b) General nature of industry, business, or establishment in which employed (or employer): 085

9-BIRTHPLACE (State or Country): Russia

PARENTS.

10-NAME OF FATHER: Nathan Union

11-BIRTHPLACE OF FATHER (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Balto St

15-

Filed JUL 21 1920 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Pleurisy
Pleurisy Purulent

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M Hurley M. D.
(Coroner)

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Woodmen Circle, Mt. Carmel — DATE OF BURIAL: July 21, 1920.

20-UNDERTAKER: Jack Lewis — ADDRESS: 1411 E Balto St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44975 D44975

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp ST.; 3 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isador Alk

(Residence in Baltimore: No. 1532 E. Pratt Street St.; 16 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown (Month) (Day) 1890 (Year)

7-AGE. 30 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Insurance Agt
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER. Morris

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Ida Cohen

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Lewis

(Address) 1411 E. Baltimore

15-

Filed JUL 21 1920, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 20 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15 1920, to July 20, 1920, that I saw him alive on July 20 1920, and that death occurred, on the date stated above, at 7 00 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis

(Duration) yrs. mos. 5 ds.

(Signed) Louis Sachs M. D.

July 20, 1920. (Address) The Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 5 ds. In the State 16 yrs. mos. ds.

Where was disease contracted if not at place of death? At Home

Former or usual residence 1532 E. Pratt St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Cemetery — DATE OF BURIAL, July 21, 1920

20-UNDERTAKER Jos. Lewis — ADDRESS 1411 E. Balto

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 44976 HEALTH DEPARTMENT--CITY OF BALTIMORE ✓ D44976

CERTIFICATE OF DEATH

8-091

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 122 N Paca St. 4 WARD)

Registered No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Baby Chin

(Residence in Baltimore: No. 122 N. Paca St.)

5 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Yellow Chinese

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: July (Month) 2 (Day), 1920 (Year)

7 AGE: ..... yrs. ..... mos. 18 ds. | If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Chin Dunn

11 BIRTHPLACE OF FATHER (State or country): China

12 MAIDEN NAME OF MOTHER: Shu See

13 BIRTHPLACE OF MOTHER (State or country): China

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chin Dunn

(Address) 122 N. Paca

15 Filed JUL 21 1920 ROBERT P. LAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 20 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1920, to July 20, 1920, that I saw h[illegible] alive on July 20, 1920, and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) ..... yrs. ..... mos. 9 ds

Contributory (SECONDARY) Bronchopneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Jerome N. Byrne M. D.

July 20, 1920. (Address) 570 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Baltimore | DATE OF BURIAL: July 21, 1920

20 UNDERTAKER: John O Mitchell | ADDRESS: [illegible]

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dyer.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44977 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D44977

CERTIFICATE OF DEATH. 138

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. St.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Wm. Caroline Dyer.

(a) RESIDENCE. NO. The Walbert apts. Chas. Lafayette Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of F. M. Dyer.

6 DATE OF BIRTH (month, day, and year) June 25, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	—	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER George Reinecke.

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Virginia Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mr F. M. Dyer (Address) 18 E Lexington St.

15 Filed JUL 21 1920 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/19 1920

17 I HEREBY CERTIFY, That I attended deceased from 7/N 1924 to 7/19 1920, that I last saw h alive on 7/19 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Cardiac dil

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 7/15

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emma L. Ridgely, M. D.

7/19, 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	7-21 1920
20 UNDERTAKER Henry W. Peckinpaugh Sons Co	ADDRESS Mc Culloh & Orchard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44978

CERTIFICATE OF DEATH.

18 D 44978

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1821 Castle ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna E Meyer

(a) RESIDENCE. No. 1821 Castle ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookbinder 064

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer not known

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Kluber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mary Meyer
(Address) 1821 Castle St

15 Filed JUL 21 1920 ROBERT F. LEADER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1920

17 I HEREBY CERTIFY, That I attended deceased from May 19 1920, to July 20, 1920, that I last saw her alive on July 20, 1920, and that death occurred, on the date stated above, at 11A m.

The CAUSE OF DEATH* was as follows: Pulmonary Phthisis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mon. 1 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H Hammond Lee M. D.

, 19 (Address) 835 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL July 22 1920

20 UNDERTAKER Mr & Mrs John W. Temple

ADDRESS 801 W. Fayette

N. B.—NAME OF DECEASED should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44979 HEALTH DEPARTMENT—CITY OF BALTIMORE D44979

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2029 Druid Hill Av ST.; 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. W. Perry

(a) RESIDENCE. No. 2029 Druid Hill Av ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lucy M. Perry

6 DATE OF BIRTH (month, day, and year): September

7 AGE: Years 56 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of Industry, business, or establishment in which employed (or employer): in Department

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Chas. B. Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington D.C.

12 MAIDEN NAME OF MOTHER: Mary Ann Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D.C.

14 Informant (Address): Lucy M. Perry 2029 Druid Hill Ave

15 Filed JUL 21 1920 Registrar: ROBERT E. LAZENBY Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/18 1920

17 I HEREBY CERTIFY, That I attended deceased from 7/13, 1920, to 7/18, 1920, that I last saw h[illegible] alive on 7/18, 1920, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Arteriosclerosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bright Rhette, M. D.

19 (Address) 2134 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem.

DATE OF BURIAL: July 22 1920

20 UNDERTAKER: David F. Hunsley

ADDRESS: 75 W. Biddle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D44980

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44980

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. on R.R. Trans in Cecil Co. nr) ST. 24 WARD)

REGISTERED No. C 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph J. Clough

(Residence in Baltimore: No. 1501 Henry St.) St. (yrs. 60 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ...Oct.... (Month) 7 (Day) 1863 (Year)

7-AGE, 56 yrs. 9 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work R.R. Conductor
(b) General nature of industry, business, or establishment in which employed (or employer) 073

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER, Thos Clough

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Mary Rhodes

13-BIRTHPLACE OF MOTHER (State or Country), R. I.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Clough

(Address) 1501 Henry St

15-

Filed JUL 21 1920, 191.... Registrar.

ROBERT P. KRAUSE
BURIAL PERMIT

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.... (Inquest, autopsy or inquiry.) ....find that said deceased came to.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

a few hours
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Don't know of any

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. K. Jones M. D.
(Coroner.)

7-21-, 1920 (Address) 117 N. Sarato[illegible] St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Carmel Cem	July 22 1920
20-UNDERTAKER H. Sander Sons	ADDRESS 1910 Reed St

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44981 ✓ 105 D 44981

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2110 E. Biddle St.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida E. Travers

(a) RESIDENCE. NO. 2110 E. Biddle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank H. Travers

6 DATE OF BIRTH (month, day, and year): Aug 31 - 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General natore of indostry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Isaak Beatley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ballo Maryland

12 MAIDEN NAME OF MOTHER: Mary J. Bishop

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ballo Maryland

14 Informant: Hugh Bryden
(Address): 2110 E. Biddle St

15 Filed JUL 21 1920, 19 ... Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 1920

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1920, to July 18, 1920, that I last saw her alive on July 17, 1920, and that death occurred, on the date stated above, at 445 A. m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Joseph E. Eisenbrey M. D.

(Address) 201 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem.

DATE OF BURIAL: July 21 1920

20 UNDERTAKER: H. Sander Sons

ADDRESS: 1711 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should make mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- it may be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 44982

HEALTH DEPARTMENT--CITY OF BALTIMORE

D-44982

CERTIFICATE OF DEATH.

138

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univerrity Hospital ST.: 1st WARD) 18

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Marie (Harry H) Jones

(a) RESIDENCE. No. 31 S Schroeder ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred all life yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry H Jones

6 DATE OF BIRTH (month, day, and year) Mch 24 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Chas. F. Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Dysart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry H Jones.
(Address) 31 S Schroeder St

15 Filed JUL 21 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1920

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1920, to death on day.

that I last saw h.r alive on July 18, 1920

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) yrs. moe. 7 ds.

CONTRIBUTORY (Secondary) Operation of Version & Breech Ext

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of July 18-20

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. Hooper (Dr Hosp) M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — DATE OF BURIAL: 7/21/20

20 UNDERTAKER: Geo A Farley Assistant — ADDRESS: Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 44983 HEALTH DEPARTMENT—CITY OF BALTIMORE D 44983

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern Hospital ST.; 20 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine A. Rigney

(Residence in Baltimore: No. 1913 Collins St.; 51 yrs. 11 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	White	Widow

6-DATE OF BIRTH, July 25, 1868 (Month) (Day) (Year)

7-AGE, 51 yrs. 11 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country). Balto

PARENTS.

10-NAME OF FATHER, John Murray

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nicholas Ingris

(Address) 1913 Hollins St

15- Filed JUL 21 1920 191..... G. H. Gresse Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 20 (Month) 20 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 3 1920, to July 20 1920, that I saw her alive on July 19 22 1920, and that death occurred, on the date stated above, at 5 30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) .....yrs. .....mos. 6 ds.

CONTRIBUTORY (Secondary) Asthenia

(Duration) .....yrs. 2 mos. .....ds.

(Signed) Flora Wallach M. D.

July 20, 1920 (Address) 1112 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Family or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loretto — DATE OF BURIAL. July 22 1920

20-UNDERTAKER Geo. J. Schmidt & Bro — ADDRESS 2101 Eutaw Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Pks.

D44984 HEALTH DEPARTMENT—CITY OF BALTIMORE D44984

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Henderson

(a) RESIDENCE. NO. 2000 E. 31st St. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83			

8 OCCUPATION OF DECEASED 050

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,

(Address) New City Hospital.

15 Filed ..... 19 .....

JUN 21 1920

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20, 1920

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1917, to July 20, 1920, that I last saw h im alive on July 20, 1920, and that death occurred, on the date stated above, at 9:15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Opt ided Hemorrhage

(Signed) G. H. Wilkinson M. D.

7/20/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	July 22 1920
20 UNDERTAKER	ADDRESS
Wm Cook	1026 E Fork

N. B.—WRITE PLAINLY with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should be careful in the statement of OCCUPATION. Information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 44985

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 44985

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard D. Robinson

(a) RESIDENCE. No. Phoenix Md ST., WARD.

(Usual place of abode) Phoenix Md

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 0 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 1877.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
43	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Farming

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Towson Md

PARENTS

10 NAME OF FATHER Wm J. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland Ireland

12 MAIDEN NAME OF MOTHER Mary Ellen Hawley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records of Mt Hope Retreat

(Address) Mt Hope Retreat

15 Filed JUL 21 1920, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 12- 19 11 to July 20th 1920.

that I last saw him alive on July 20th 1920,

and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Suddenly Acute Dilatation of the Heart

Sudden (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chr. Parenchymatous Nephritis (duration) 9 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Phoenix Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery M. D.

July 26th, 19 20 Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Maria Cem

DATE OF BURIAL: July 23 1920

20 UNDERTAKER: Wm Cook & Son E Baltimore

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44986

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44986

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2924 Riggs Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L. Sanner

(a) RESIDENCE. No. 2924 Riggs Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence L. Sanner

6 DATE OF BIRTH (month, day, and year) March 29/1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Chesapeake Coal Co Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER George Sanner

11 BIRTHPLACE OF FATHER (city or town) St. Marys Co Md
(State or country)

12 MAIDEN NAME OF MOTHER Jane Richardson

13 BIRTHPLACE OF MOTHER (city or town) New York State
(State or country)

14 Informant Florence L. Sanner
(Address) 2924 Riggs Ave

15 Filed JUL 21 1920 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1920

17

I HEREBY CERTIFY, That I attended deceased from 7-20-1920 at 8 a.m. & found him dying, that I last saw him alive on July 20 1920, and that death occurred, on the date stated above, at 9 30 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs & throat.

(duration) Given as about 1 yr.

CONTRIBUTORY (Secondary) X (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis? Do not know.

(Signed) O. H. Hoffman, M. D.

19 (Address) 2100 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 22 1920

20 UNDERTAKER Wm Cook Sons & Moulton ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1944987 — 1944987

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Russell St. Mt Winans ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lana F. Parker

(Residence in Baltimore: No. Russell St. Mt. Winans St.; 20 yrs., .mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1863 (Year)

7-AGE,	If LESS than 1 day,
57 yrs. mos. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Sarah Travers

(Address)..... Russell St Mt Winans

15- JUL 21 1920 Filed....., 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 19 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1920, to July 19 1920, that I saw her alive on July 19 1920, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(Duration) 2 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. V. Glasgow M. D.

, 191... (Address) Lakeland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn.	July 21, 1920
20-UNDERTAKER	ADDRESS
Edw. Kinggold	1463 Carey St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

1044988

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044988

CERTIFICATE OF DEATH

151

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1514 Division ST.; WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond Taylor

(Residence in Baltimore: No. 1701 Patapsco St. St.; ....yrs.,....mos....da.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April (Month) 9 (Day), 1920 (Year)

7-AGE, ...yrs. 3 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ballo Md

PARENTS.

10-NAME OF FATHER, Joseph Taylor

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Nane Schaffer

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Hughes

(Address) 1514 Division St

15- Filed JUL 21 1920 191. Burial Permit Issued ROBERT S. BRADEN Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 20 (Day), 1920 (Year)

17-I HEREBY CERTIFY, That I attended deceased from May 21 1920 to July 20 1920, that I saw h alive on July 20 1920, and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis

(Duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary) Static Encephalitis

(Duration) ....yrs. ....mos. 1 ds.

(Signed) Walter Hughes M. D.

7-21, 1920 (Address) 1514 Division St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem. DATE OF BURIAL, July 21 1920

20-UNDERTAKER James Dignan & Son ADDRESS 1100 E. Pratt

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1044989 HEALTH DEPARTMENT--CITY OF BALTIMORE 1044989

CERTIFICATE OF DEATH

151

1-PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 1209 Chatham ST. 8 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmore Scott

(Residence in Baltimore: No. 1209 Chatham St.; ..... yrs. 7 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male

4-COLOR OR RACE Colored

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH November 26, 1919 (Month) (Day) (Year)

7-AGE ..... yrs. 7 mos. 5 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) ——

9-BIRTHPLACE (State or country) Baltimore Md

PARENTS

10-NAME OF FATHER Ernest Scott

11-BIRTHPLACE OF FATHER (State or country) Virginia

12-MAIDEN NAME OF MOTHER Upperthumbert

13-BIRTHPLACE OF MOTHER (State or country) Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest Scott

(Address) 1209 Chatham

15-

Filed JUL 21 1920, 191 ROBERT P. LAUTER Clerk

Burial Permit Issued REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July 20, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 17, 1920 to July 20, 1920 that I saw h.. alive on July 20, 1920 and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) yrs. 2 mos. ds

Contributory (SECONDARY) Asthenia

(Duration) yrs. mos. 10 ds.

(Signed) Clement Carter M. D.

July 21, 1920 (Address) 1401 W Lan..

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Loudon Cemetery

DATE OF BURIAL July 24, 1920

20-UNDERTAKER Chas G Bailey

ADDRESS 143 Jefferson st

Spec.—8-24-14—M. & T.—2000 Bks.

D 44990 HEALTH DEPARTMENT—CITY OF BALTIMORE D 44990

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. C

CITY OF BALTIMORE: (No. 15 W Dimeon St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lee Cottrill

(Residence in Baltimore: No. Union B. H. St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH October 11, 1869 (Month) (Day) (Year)

7-AGE, 57 yrs. mon. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Foreman
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), W. Va.

PARENTS.

10-NAME OF FATHER, Jas Cottrill

11-BIRTHPLACE OF FATHER (State or Country), W. Va.

12-MAIDEN NAME OF MOTHER Flora Keller

13-BIRTHPLACE OF MOTHER (State or Country), W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wallace Hughes

(Address) 15 W Dimeon St

15-

Filed JUL 21 1920, 191.. ROBERT J. BRAUTIGAM Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 21, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1920, to July 21 1920; that I saw h live on July 21 1920, and that death occurred, on the date stated above, at 9 12 a m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

(Duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) Tuberculous Pleurisy

(Duration) yrs. mos. da.

(Signed) Wallace Hughes M. D.

7-21, 1920. (Address) 15 W Dimeon St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Weston W Va.

19-PLACE OF BURIAL OR REMOVAL, Weston West Va — DATE OF BURIAL, July 21, 1920

20-UNDERTAKER W M Cook — ADDRESS 502 E Nath

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44991

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44991

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 924 W Lombard ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Duffy.

(a) RESIDENCE. NO. 924 W Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Duffy.

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): ———

(c) Name of employer: ———

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: William C Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Ann Hagan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Mrs Polly Reynolds (Address) 924 W Lombard St.

15 Filed JUL 21 1920 19 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7. 19 1920

17 I HEREBY CERTIFY, That I attended deceased from July 16 . 1920, to July 19 . 1920.

that I last saw h e alive on July 19 . 1920.

and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. E. Brunn M. D.

7-21 1920 (Address) 907 N Schroeder St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral DATE OF BURIAL: July 21 1920

20 UNDERTAKER: John J Cowan & Son ADDRESS: 901 Hollins St

N. B.—WRITE PLAINLY. WITH UNFADING INK—PENCIL WILL NOT COPY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

044992. HEALTH DEPARTMENT—CITY OF BALTIMORE 044992.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 Park Avenue ST.: 14 WARD) REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas K. Le Brou

(a) RESIDENCE. NO. 1700 Park Avenue ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Busk

6 DATE OF BIRTH (month, day, and year) Sept. 9, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retail Hat Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 043

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER John F. Le Brou

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Elizabeth M. Aitken

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant Mrs. Virginia Le Brou
(Address) 1700 Park Avenue

15 Filed JUL 21 1920, 19... ROBERT E. LEATHERS Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov, 19..., to July 20, 19..., that I last saw h... alive on July 12, 19..., and that death occurred, on the date stated above, at ... a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Aortic Regurg. Cardiac
Hypertr., Pulmonary congestion and

(duration) 5 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) C. Urban Smith, M. D.

19 (Address) 817 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	7/23 19 20
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 44993 HEALTH DEPARTMENT—CITY OF BALTIMORE D 44993

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 501 Walnut ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Davis

(a) RESIDENCE. No. 501 Walnut ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 9 ds. How long in U. S., if of foreign birth? yrs. 3 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 12 1925

7 AGE — Years: — Months: 3 Days: 9 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ooo

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Margt Hall

(Address): 501 Walnut alley

15 Filed ..... 19 .....

G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/21/1920

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1920, to July 21, 1920, that I last saw h.. alive on July 20, 1920, and that death occurred, on the date stated above at 4 30 P.M.

The CAUSE OF DEATH* was as follows:

Dyspnea

8 hours

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Gastro-Enteritis

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Jno. H. Tompsons M. D.

, 19 (Address) 1019 Druid Hill ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: July 21 1920

20 UNDERTAKER: Sam. W. Chaseman

ADDRESS: 1900 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS ... PHYSICIANS should state ... mation should be carefully supplied. AGE should be ... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of ... ...

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 44994 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D44994

105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2523 W Baltimore St., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Myers

(a) RESIDENCE. No. 2523 W Baltimore St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Myers,

6 DATE OF BIRTH (month, day, and year) Mar 10, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	4	11	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Coppersmith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant W. T. Warren
(Address) 2523 W. Baltimore

15 Filed ..... 19 .....

JUL 21 1920

Registrar C. H. Grese

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1920.

17 I HEREBY CERTIFY, That I attended deceased from July - 1 - 1920, to July - 21, 1920 that I last saw h[illegible]alive on July 21, 1920 and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion,

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marlin W Shook M. D.

19 (Address) 8064 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Burial Comty	7/23 1920
20 UNDERTAKER	ADDRESS
H Barnhard & Son	Westminster Md

AGE should be carefully supplied. Age of infants should be stated EXACTLY. PHYSICIANS should write so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D44995

HEALTH DEPARTMENT—CITY OF BALTIMORE

14 B 244995

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 W Franklin ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E Clark

(Residence in Baltimore: No. 919 W Franklin St.; 79 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec 27, 1860 (Month) (Day) (Year)

7-AGE, 49 yrs. 6 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fireman
(b) General nature of industry, business, or establishment in which employed (or employer): 032

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thomas Clark

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine Kelly

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E Clark

(Address) 919 W. Franklin St

15-

Filed JUL 21 1920, 191.....

G. H. Grese. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 20, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 7-10 1920, to 7-20 1920, that I saw him alive on 7-19 1920, and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Septic Intoxication

..... (Duration) ..... yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Carbuncle

..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Elijah L Russell M. D.

7-21, 1920 (Address) 1516 W Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Cathedral — DATE OF BURIAL, 7-22, 1920

20-UNDERTAKER H C Brannigan Co — ADDRESS 517 N Schroeder St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D44996 HEALTH DEPARTMENT—CITY OF BALTIMORE D44996

CERTIFICATE OF DEATH. 104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2022 Aliceanna ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME EDWARD SIECEJSKI,

(a) RESIDENCE. No. 2022 Aliceanna ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male,	White,	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 1/19.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.,

PARENTS

10 NAME OF FATHER Antoni Siecejski,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Katie Krol,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Antoni Siecejski, (Father)
(Address) # 2022 Aliceanna Street.

15 Filed JUL 21 1920 19 ROBERT J. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUL 21 1920

17 I HEREBY CERTIFY, That I attended deceased from July 18 , 19 20 to July 24 , 19 20.
that I last saw h— alive on July 24 , 19 20.
and that death occurred, on the date stated above, at 5.15 A— m.
The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Weinland, M. D.

July 21, 1920 (Address) 1 N. S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cemetery,	July 22. 1920

20 UNDERTAKER M. F. Sadowski, ADDRESS 905 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

L044997

HEALTH DEPARTMENT—CITY OF BALTIMORE

L044997

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. near Wagners Pt 25 Fairfield ST.; 104 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislaw F. Plock

(Residence in Baltimore: No. Fairfield St.; ..... yrs., 7 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Dec. 1 (Month) (Day) 1919 (Year)

7-AGE, ... yrs. 7 mos. 20 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... " "

9-BIRTHPLACE, (State or Country), Fairfield

PARENTS.

10-NAME OF FATHER, John Plock.

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Marta Wojna

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Plock

(Address) Fairfield

15- Filed JUL 21 1920, 191... ROBERT B KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 20, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 10 1920, to July 20 1920, that I saw him alive on July 20 1920, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Acidosis

(Duration) ... yrs. ... mos. 5 ds.

(Signed) Leon D. Horica M. D.

July 20, 1920 (Address) Curtis Bay, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross

DATE OF BURIAL, July 22., 1920.

20-UNDERTAKER William Galloway

ADDRESS 618 Eastern

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D44998

HEALTH DEPARTMENT—CITY OF BALTIMORE

D44998

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1909 Wilhelm ST. 70 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A Lineman

(Residence in Baltimore: No. 1909 Wilhelm St.; 70 yrs., 5 mos. 14 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Feb 4, 1855
(Month) (Day) (Year)

7-AGE, 70 yrs. 5 mos. 14 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Richard Lee

11-BIRTHPLACE OF FATHER (State or Country), Balto City,

12-MAIDEN NAME OF MOTHER Sarah Norris

13-BIRTHPLACE OF MOTHER (State or Country), Balto. City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William J Lineman

(Address) 1909 Wilhelm Street

15-

Filed....., 191.....

BURIAL PERMIT Clerk.....

Registrar.

JUL 21 1920 ROBERT F KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 18, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1, 1920, to July 18 1920, that I saw h[illegible] alive on July 16. 1920, and that death occurred, on the date stated above, at 9.45 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Tuberculosis,

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary

(Duration) yrs. mos. 6 ds.

(Signed) C B Wilson M. D.

7-22, 1920 (Address) 1915 Hollins Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cemetery	July 22, 1920
20-UNDERTAKER Joseph B Cook	ADDRESS 1003 N Bal St

Spec.—8-24-14—M. & T.—2000 Bks.

1044999

HEALTH DEPARTMENT—CITY OF BALTIMORE

1044999

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1939 Fidences ave ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Saint Elizabeth Kingsbury

(Residence in Baltimore: No. 1939 Fidences ave St.; 17 yrs., 10 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, September 7th, 1902 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
17 yrs. 10 mos. 13 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Arthur Wellington Kingsbury

11-BIRTHPLACE OF FATHER (State or Country), Montandon, Pa.

12-MAIDEN NAME OF MOTHER Mary Ellen Shaffer

13-BIRTHPLACE OF MOTHER (State or Country), Mercersburg, Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Russell L. Kingsbury

(Address) 1939 Fidences ave

15-

Filed JUL 21 1920, 191.... ROBERT B. LEACH Registrar.

BURIAL PERMIT

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 20th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1st 1920, to July 20th 1920, that I saw her alive on July 19th 1920, and that death occurred, on the date stated above, at 9A. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 3 ds.

(Signed) Arthur F. Kellman M. D.

July 20, 1920. (Address) 122 W. Lafayette ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, London Park Cem. DATE OF BURIAL, July 21, 1920

20-UNDERTAKER Joseph L. B. Cook ADDRESS 1003 W. Balto Street

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045000

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045000

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 20 N. Mount St. 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jos. Farrell

(a) RESIDENCE. No. 20 N. Mount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) April 14, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
58	5	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Oppenheim-Oberndorf

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Peter Farrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Egan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Catherine M. Farrell

(Address) 20 N. Mount St

15 Filed JUL 21 1920 19 ROBERT B. KRAUTER Registrar

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1920

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1920, to July 20, 1920, that I last saw h~~im~~ alive on July 19, 1920, and that death occurred, on the date stated above, at 6.15 a.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver

(duration) yrs. mos. 27 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of —

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Mac O'Neill M. D.

July 20, 1920 (Address) 108 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	July 22 1920
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1025 W Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

D45001

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45001

CERTIFICATE OF DEATH.

120

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 934 Lemmon ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ollie M. Crouch,

(Residence in Baltimore: No. 934 Lemmon St. St. 5 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White.	Married

6-DATE OF BIRTH. March 4, 1900
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
20 yrs. 4 mos. 16 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER. James Ferguson,

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Sadie Harmon,

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Ferguson

(Address) 934 Lemmon St

15- JUL 22 1920 ROBERT E KRAUTER

Filed....., 19.. ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 30., 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1920, to July 30. 1920, that I saw h.. alive on July 30. 1920, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Thaston M. D.

7/20, 1920 (Address) 888 W. Lmt. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Peters.	July 23 1920
20-UNDERTAKER	ADDRESS
J. Thos. Struble 1200	W. Lmt. St.

N. B.—Every item of information should be carefully supplied. WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPERATIVE. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45002

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D45002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Vincent Dep Asylum ST. 14 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent De Paul Deal Thrope

(a) RESIDENCE. No. St Vincent Dep Asylum ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Ena Deal Thrope

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant E. W. Matthews
(Address) St Vincent Dep Asylum

15 Filed JUL 22 1920 ROBERT R. LEANTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1920

17 I HEREBY CERTIFY, That I attended deceased from April 30 1920 to July 19 1920
that I last saw her alive on July 19 1920
and that death occurred, on the date stated above, at 1 P m.
The CAUSE OF DEATH* was as follows:

Enteritis acute

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 2 mos. 19 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Chas H Claytor M. D.

19 (Address) 1524 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	July 22 1920

20 UNDERTAKER M Fahey & Sons ADDRESS 1827 W Pratt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45003. HEALTH DEPARTMENT—CITY OF BALTIMORE D45003.

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507 McCulloh St.: 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Hyder Dwyer

(a) RESIDENCE. No. 1507 McCulloh ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. \ mos. \ ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Dwyer

6 DATE OF BIRTH (month, day, and year): 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none (old)

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Philip Hyder

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Mary Bevan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): Elizabeth Dwyer 1507 McCulloh St

15 Filed JUL 22 1920 ROBERT E. LAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1920

17 I HEREBY CERTIFY, That I attended deceased from July 12 1920 to July 21 1920.

that I last saw h alive on July 21 1920.

and that death occurred, on the date stated above, at 8 30 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Lauber M. D.

July 22 1920 Address 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lakestown Md.	July 27 20

20 UNDERTAKER: H Fahey & Sons. ADDRESS: 1887 W Mad

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45004

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D45004

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 735 E-30th ST.; 9 WARD)

2-FULL NAME Frederick Edwin Stanley

(a) RESIDENCE. No. 735 E-30th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Stanley

6 DATE OF BIRTH (month, day, and year) Sept 27 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Alfred Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Smith Knew

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Alice Stanley
(Address) 735 E-30th St.

15 Filed JUL 22 1920 ROBERT F. KEATOR Registrar BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1919, to July 18, 1920, that I last saw h... alive on July 18, 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lung.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? yes

(Signed) H. G. Shriber M. D.

. 19 (Address) 632 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 23 1920
20 UNDERTAKER	ADDRESS
Wm Cook	W. Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Mygreen.

14634 L 45005

HEALTH DEPARTMENT—CITY OF BALTIMORE

L 45005

CERTIFICATE OF DEATH.

X 123

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital; 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Mcgregor

(a) RESIDENCE. No. Eastman W. Fairmount ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 9-1864

7 AGE 55	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Diggers 086

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Peter Mcgregor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Cornelia Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Hospital Record
(Address) J. H. H.

15 Filed JUL 22 1920 ROBERT B. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19— 1920

17 I HEREBY CERTIFY, That I attended deceased from June 19—, 1920, to July 19—, 1920, that I last saw him alive on July 19—, 1920, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia due to Pyelonephritis

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Senile Calculus.

(duration) 5 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Ust Unp. ?

Did an operation precede death? Yes. Date of June 7 1920

Was there an autopsy? Yes.

What test confirmed diagnosis? Yes.

(Signed) Harvard B. Cecil, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	July 22 1920

20 UNDERTAKER	ADDRESS
William G. Schaeffer	1816 Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

245006 ✓ 15/245006

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1 W. Potomac St. ST. 25 WARD) Brooklyn

2-FULL NAME Josephine Woodard

(a) RESIDENCE. NO. 1 W. Potomac St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Dupont

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
—	—	1	1 hr

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 100

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Brooklyn Md

PARENTS

10 NAME OF FATHER Charles A. Woodard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Brooklyn Md

12 MAIDEN NAME OF MOTHER Katie A. Sapp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Brooklyn Md

14 Informant Mr. Chas Woodward
(Address) 1 W. Potomac St.

15 Filed JUL 22 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1920

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1920, to 9½ am 19 , that I last saw h[illegible] alive on July 21, 1920, and that death occurred, on the date stated above, at July 21 m.

The CAUSE OF DEATH* was as follows: Pneumonia Croupous

6½ months
(duration) yrs. mos. ½ ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death? Premature

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 1568 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem DATE OF BURIAL 7/22 1920

20 UNDERTAKER J. Fran McCully ADDRESS 130 E. Fort

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1045007 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 1045007

CERTIFICATE OF DEATH.

REGISTERED No. C 174

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Foot of Decatur St. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry F. Brown.

(Residence in Baltimore: No. 1242 William St. St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. April 5th. 1900. (Month), 1 (Day) (Year)

7-AGE. 20 yrs. 3 mos. 15 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer. 040
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Orwigsburg Pa.

PARENTS.

10-NAME OF FATHER, Harry L. Brown.

11-BIRTHPLACE OF FATHER (State or Country), North Mansheim Pa.

12-MAIDEN NAME OF MOTHER Gertrude DeLong.

13-BIRTHPLACE OF MOTHER (State or Country), McKeansburg Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry L. Brown. (father)

(Address) Orwigsburg Pa.

15- Filed JUL 22 1920, 191 ROBERT E KRAUTER Registrar

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 20th. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the Skull.
Struck on the head by accidental falling of a boom (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto F. Einhardt M. D. (Coroner.)

Jul 21., 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Orwigsburg Pa — DATE OF BURIAL, 7/24, 1920

20-UNDERTAKER J. Fahy & Sons — ADDRESS 1318 Light St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45008

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45008

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1543 Argyle ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Turner

(a) RESIDENCE. NO. 1543 Argyle ave ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20/1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frederick Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella Manson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Ella Turner 1543 Argyle Ave

Filed JUL 22 1920 19 ROBERT E. KRAUTER Registrar

Burial Permit Work

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1920

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1920, to July 21, 1920, that I last saw h.. alive on July 20, 1920, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) James Brown M. D.

7/22/20 (Address) 1837 Bruns Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	July 22 1920

20 UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec. 6-9-19—H. P. Co.—1000 Bks.

D45009

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45009

CERTIFICATE OF DEATH.

15-28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1405 N. Calhoun ST.; WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie L. Brown

(a) RESIDENCE. NO. 1405 N. Calhoun ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ambrose Brown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia Jefferson Co

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Nat Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Ambrose Brown 1405 N. Calhoun St

15 Filed JUL 22 1920 19 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20th 1920

17 I HEREBY CERTIFY, That I attended deceased from June 11th 1920. to July 19th 1920.

that I last saw her alive on July 19th 1920.

and that death occurred, on the date stated above, at 6.05 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Tb Lung

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical

(Signed) Leo. H. Lautenbach M. D

1920 (Address) 2215 W. Baltimore.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 22 1920

20 UNDERTAKER ADDRESS

JAMES H. DENNIS

1303 PRESTMAN ST

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45010

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45010

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Marie Tierney

(a) RESIDENCE. No. 614 N. 23rd Phila Pa ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 0 ds. How long in U. S., if of foreign birth? Life yrs. mos ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 28 - 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
28	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework -

(b) General nature of industry, business, or establishment in which employed (or employer) Domesticity -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila - Pa

PARENTS

10 NAME OF FATHER Michael Tierney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Cosgrove

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md

15 Filed JUL 22 1920 Burial Permit Issued Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21st 1920

17 I HEREBY CERTIFY, That I attended deceased from Mar 23rd, 1919, to July 21st, 1920, that I last saw her alive on July 21st, 1920, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Pleuritis - with effusion -
Probably Tubercular -

(duration) 0 yrs. 0 mos. 12 ds.

CONTRIBUTORY (Secondary) Melancholia

Obt (duration) 3 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Phila Pa

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D

July 22nd, 1920 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia	July 24 1920
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45011 HEALTH DEPARTMENT—CITY OF BALTIMORE D45011

CERTIFICATE OF DEATH. 104-091

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 S. Fourth ST. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christena E. Schmiedicke

(a) RESIDENCE. No. 701 S. Fourth ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 15-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Otto Schmiedicke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Steinbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Otto Schmiedicke

(Address) 701 S. Fourth St.

15 JUL 22 1920 ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1920

17 I HEREBY CERTIFY, That I attended deceased from 7/20, 1920, to 7/22, 1920, that I last saw h[illegible] alive on 7/21, 1920, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

1 Broncho Pneumonia.

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Ileo colitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? Complement Fixation

(Signed) J. H. Carroll M. D.

7/22 1920 (Address) 633-S-Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL July 23 1920

20 UNDERTAKER Birkler & Birkler

ADDRESS 1739 Eager

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045012

CERTIFICATE OF DEATH.

1045012

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2109 Wilkens Ave St.; Ward)

REGISTERED No. C 20 28

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Kerber

(Residence in Baltimore: No. 2109 wilkens ave St.; 15 yrs. mos. ds.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Sing'e

6-DATE OF BIRTH: February 8, 1905 (Month) (Day) (Year)

7-AGE: 15 yrs. 5 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): work

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: John L Kerber

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Mary A. Murphy

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. John L Kerber

(Address) 2109 Wilkens Ave

15- Filed JUL 22 1920, 191.. ROBERT F. KRAUSER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 21, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 10 1920, to July 21 1920, that I saw her alive on July 20 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Exhaustion

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) yrs. mos. ds.

(Signed) Robert C. Kerber M. D.

July 21, 1920 (Address) 2151 Waltman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Ft Cedar Cem — DATE OF BURIAL: July 24, 1920

20-UNDERTAKER: John Howard & Son — ADDRESS: 901 Hollins

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45013

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45013

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 731 S. Glover ST.; 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Steven F. Bromey

(a) RESIDENCE. NO. 731 S. Glover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Steven Bromey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Anna Fabalg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

11 Informant Steven Bromey

(Address) 731 S. Glover St

15 FILED JUL 22 1920 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1920

17 I HEREBY CERTIFY, That I attended deceased from July 15 1920, to July 22 1920.

That I last saw h— alive on July 22 1920.

and that death occurred, on the date stated above, at 8.25 a. m.

The CAUSE OF DEATH* was as follows:

Gastro. Enteritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) General Toxaemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Hand

(Signed) Dr. P. Brantner, M. D.

22/7 1920 (Address) 1255 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 24 1920
20 UNDERTAKER Frank Enoch Son	ADDRESS 1900 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45014 HEALTH DEPARTMENT—CITY OF BALTIMORE D45014

(265) CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 265 S. Bond ST.: 2 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie C. Nolan

(a) RESIDENCE. NO. 265 S. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barthalomew Nolan

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home 137

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Andrew Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Grady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. Bartholomew Nolan

(Address) 625 S. Bond st.

15 JUL 22 1920 ROBERT E. LEAVITT Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20th 1920

17 I HEREBY CERTIFY, That I attended deceased from May, 1920, to July 20th, 1920, that I last saw h[er] alive on July 19th, 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis, Aortic and Mitral Regurg., Chronic Bronchitis

1 year
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY —
(Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) A. F. Ries, M. D.

July 20th, 1920 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	July 23 1920

20 UNDERTAKER	ADDRESS
Jos. J. Herr	156 N. Luzerne

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45015

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45015

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3908 Park Heights Ave WARD) 15 — REGISTERED NO. 92

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Samuel M Field
3908 Park Heights

(a) RESIDENCE. No. 3908 Park Heights ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Field

6 DATE OF BIRTH (month, day, and year) Sept 29-1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Doctor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Jno Wolf Field

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Mar Masters

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Samuel Field
(Address) 3908 Park Heights Ave

15 Filed JUL 22 1920 19 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1920

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1920, to July 21, 1920, that I last saw him alive on July 20, 1920, and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 8 yrs. 7 mos. 10 da.

CONTRIBUTORY (Secondary) old age

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) James L Ashurst M. D.

(Address) 402 Park Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: Jul 22 1920

20 UNDERTAKER: W E Chesshire & Son — ADDRESS: Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAKE NO RESERVATIONS

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

845016

CERTIFICATE OF DEATH.

15 845016

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1527 W. Fayette ST.; 19 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Phelps

(Residence in Baltimore: No. 1527 W. Fayette St.; ....yrs. ....mos. 8 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 14 (Day), 1920 (Year)

7-AGE, — yrs. — mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Richard E. Phelps

11-BIRTHPLACE OF FATHER (State or Country), NC

12-MAIDEN NAME OF MOTHER Gladys K McDonald

13-BIRTHPLACE OF MOTHER (State or Country), NC

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R E Phelps

(Address) 1527 W. Fayette

15-

Filed JUL 22 1920 191.... ROBERT T. CRAWFORD Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 21 1920, to July 22 1920, that I saw h[illegible] alive on July 21 1920, and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:

..... Premature (Prematurity).....

..... (Duration).....yrs. .....mos. 8 ds.

CONTRIBUTORY (Secondary) Premature birth

..... (Duration).....yrs. .....mos. .....ds.

(Signed) Howard K. Warner M. D.

July 22, 1920 (Address) 2604 Garrison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. 8 ds. In the State .....yrs. .....mos.

Where was disease contracted, if not at place of death? 1527 W Fayet[illegible]

Former or usual residence 1527 W Fayet[illegible]

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem DATE O[illegible] July

20-UNDERTAKER John C. Mitche[illegible] AD[illegible]

D 45017

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1517 Linden ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Thomsen

(a) RESIDENCE. NO. 1517 Linden ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 6 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 27 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Lawrence Thomsen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Emily J. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Francis J. Thomsen (Address) 1517 Linden ave

15 Filed JUL 22 1920 ROBERT F. KLAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1920

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1920, to July 22, 1920, that I last saw her alive on July 22, 1920, and that death occurred, on the date stated above, at 1 30 A. m.

The CAUSE OF DEATH* was as follows:

Paralysis – right hemiplegia

(duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage (duration) — yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) John J. Krug, M. D.

July 22 1920 (Address) 1425 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Greenmount Cem July 23rd 1920

20 UNDERTAKER — ADDRESS

Henry H. Jenkins Sons Co. Orchard & McCulloh

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.—8-24-14—M. & T.—2000 Bks.

D 45018

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45018

104

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 2108 Gough ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen Dzimulski

(Residence in Baltimore: No. 2108 Gough St.; yrs., 6 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, January 21 1920

(Month) 21 (Day) 1920 (Year)

7-AGE, — yrs. 6 mos. 1 da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Child.
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jan Dzimulski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Maryanna Fleseni

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jan Dzimulski

(Address) 2108 Gough

15-

Filed JUL 22 1920 191.... ROBERT B BRAUER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 22, 1920.

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 17 1920, to July 22 1920, that I saw h[illegible] alive on July 21 1920, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) ... yrs. ... mos. 6 da.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... da.

(Signed) Leo Heller M. D.

July 22, 1920 (Address) 1937 Gough St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary DATE OF BURIAL, July 23..., 1920

20-UNDERTAKER John M Weber ADDRESS 1803 Bank St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

45019

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

HC 45019

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (NO. 808 N Linwood ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda H. Berg

(a) RESIDENCE. NO. 808 N Linwood Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: [illegible]

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

married, widowed, or divorced
RUSBAND of (or) WIFE of Edna A Berg

6 DATE OF BIRTH (month, day, and year) April 22 1863

7 AGE — Years: 57 — Months: 3 — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Homemaker

(b) General nature of industry, business, or establishment in which employed (or employer): 137

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Sweden

10 NAME OF FATHER: Gustav Berg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden

12 MAIDEN NAME OF MOTHER: Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweden

14 Informant: Edna A Berg
(Address): 50 E Hamburg St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1920

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1920, to July 20, 1920, that I last saw h[illegible] alive on July 20, 1920, and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Hemmorhage of stomach

(duration) yrs. mos. 2 hours

CONTRIBUTORY (Secondary) Gastric ulcer

(duration) yrs. 5 mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X ray

(Signed) Thomas Kelso, M. D.

, 19 (Address) 1001 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: July 23 1920

20 UNDERTAKER: Wm Cook — ADDRESS: N Y & K O

Spec.—8-24-14—M. & T.—2000 Bks.

1045020

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045020

CERTIFICATE OF DEATH.

1920 REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1637 Wilkens Ave ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Emmings.

(Residence in Baltimore: No. 1637 Wilkens Ave St.; 26 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widowed

6-DATE OF BIRTH, ... May (Month) 12 (Day), 1883 (Year)

7-AGE, 37 yrs. 2 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Peter Logue

11-BIRTHPLACE OF FATHER (State or Country) Ireland.

12-MAIDEN NAME OF MOTHER Nancy McGuigen

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine McKillen

(Address) 1637 Wilkens Ave.

15-

Filed JUL 22 1920, 191..... ROBERT E KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 21 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 10 1920, to July 20 1920, that I saw h.. alive on July 20 1920, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

.....

.....

Indefinite (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Malignant

.....(Duration).....yrs.....mos.....ds.

(Signed) Jos. A. Cranmer M. D.

July 22, 1920. (Address) 2687 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, July 24" 1920

20-UNDERTAKER Wm. J. Hartwell. ADDRESS 2236 W. Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45021 ✓ D 45021

CERTIFICATE OF DEATH.

137

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (St.) (Ward) K

2-FULL NAME Mr. David Pumphrey

(a) RESIDENCE. No. 1611 Lanvale St. St. Ans, WARD. 4th
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18-1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Orderly 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Robert Pumphrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary McCoy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Mrs. Mary Pumphrey 1611 Lanvale St.

15 Filed JUL 23 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22-1920

17 I HEREBY CERTIFY, That I attended deceased from July 2 . 1920 . to July 22 . 1920.
that I last saw him alive on July 21 . 1920.
and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Syphilis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wasserman reaction

(Signed) Enoch H Adams, M. D.

, 19 (Address) St Agnes Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
David Ridge Cemetery	July 24 1920
20 UNDERTAKER	ADDRESS
Jones & Faulson	14 N. Grove

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS and others should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 45022

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45022

CERTIFICATE OF DEATH.

151

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 Greenmount Ave 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Garrity

(Residence in Baltimore: No. 1310 Greenmount Ave St.: ...yrs.,...mos.....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, July (Month) 6 (Day), 1920 (Year)

7-AGE, X yrs. X mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work X
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Melvin Hyatt

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER Virginia Colarizzi

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Filed JUL 23 1920, 191... C. H. Grese. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, JUL 22 1920 (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from JUL 6 1920 191, to JUL 22 1920 191, that I saw h alive on JUL 22 1920 191, and that death occurred, on the date stated above, at 6 20 p m.

The CAUSE OF DEATH* was as follows:

Immature Premature birth

(Duration) X yrs. X mos. 16 ds.

CONTRIBUTORY (Secondary) Same

(Duration) X yrs. X mos. 16 ds.

(Signed) O. T. Durkee M. D.

JUL 22 1920, 191... (Address) 928 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cemetery — DATE OF BURIAL, 7/23/20, 191...

20-UNDERTAKER Jones & Jonelson — ADDRESS 14-N Green

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45023

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D45023

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 248 N Arlington ave ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Johns

(a) RESIDENCE. NO. 248 N. Arlington ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry Johns

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Formerly Married

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co Md

PARENTS

10 NAME OF FATHER William Ringgold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maria Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Florence Brown
(Address) 248 N Arlington ave

15 Filed JUL 23 1920 G. H. Cresse Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20th 1920

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1920, to July 20th, 1920, that I last saw her alive on July 20th, 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Cervix

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopical

(Signed) R. L. Pregel, M. D.

July 21 1920 (Address) 1707 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 23rd 1920
20 UNDERTAKER	ADDRESS
Samuel Townsend	578 N Bond

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE ... mation should be carefully supplied. AGE should be ... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of ... ck of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45024

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D45024

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1702 Cairo ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Austin

(a) RESIDENCE. NO. 1702 Cairo ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Jordan Austin

6 DATE OF BIRTH (month, day, and year) April 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stay at home W

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Buckingham Co.
(State or country) Virginia

PARENTS

10 NAME OF FATHER Red Wood

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Bettie ~~Wood~~

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Eliza Parks
(Address) 1702 Cairo St

15 Filed JUL 23 1920 19 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1920

17 I HEREBY CERTIFY, That I attended deceased from June 22 1920, to July 21 1920, that I last saw h[illegible] alive on July 21 1920, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. W. V. Cliff, M. D.

July 22 1920 (Address) 1312 N. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	July 23rd 1920
20 UNDERTAKER	ADDRESS
Samuel J. Hensley	578 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should fill in all items. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45025

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles McCarthy.

(a) RESIDENCE. NO. 2302 Race ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice V. McCarty

6 DATE OF BIRTH (month, day, and year): Jan 22 1848

7 AGE: Years 72 Months 6 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General natnre of Industry, business, or establishment in which employed (or employer): 088

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Jos. M=Carty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Alice Stritch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Norval McCarty
(Address) 2302 Race St.

15 Filed JUL 23 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 1920

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1920, to July 22, 1920, that I last saw him alive on July 22, 1920, and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Senile Hypertrophy prostate with Obstruction (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 6-19-20.

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) H. Feinstein M.D.

7/22, 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Natnre of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Winchester Va.

DATE OF BURIAL: 7/24 1920

20 UNDERTAKER: I. Frew McCully

ADDRESS: 130 E. Fork Ave

N. B.—WRITE with pen and ink. INFORMATION should be carefully supplied. AGE should be stated. EXACT CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 45026 ✓ D 64 45026

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 E Oliver St. ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A Finn

(Residence in Baltimore: No. 1622 E Olives st St.; 60 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, July (Month) 16 (Day), 1837 (Year)

7-AGE, 83 yrs. ..... mos. 5 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Michael Peter

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), ✓

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank A Finn

(Address) 915 N Gay St.

15- JUL 23 1920 Filed....., 191...

C. H. Grese. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 21 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1920, to July 21 1920, that I saw h[er] alive on July 21 1920, and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

..... Cerebral Hemorrhage .....

....

..... (Duration) ..... yrs. 24 hours mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

7/22/20, 191... (Address) 321 E 25 St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cemetery	July 24 1920
20-UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 45027

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 45027

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 N Ann St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothea Wermuth

(Residence in Baltimore: No. 412 N Ann St.; ....yrs.,....m.os.....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH ..... Sept (Month) 16 (Day), 1919 (Year)

7-AGE,	If LESS than 1 day,
.....yrs. 10 mos. 4 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000 .....

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. John Wermuth

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Emma Engel

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Wermuth

(Address) 412 N. Ann St

15-

Filed JUL 23 1920, 191.....

C. H. Grese Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15 1920 to July 22 1920 that I saw her alive on July 21 1920 and that death occurred, on the date stated above, at 7.45 m.

The CAUSE OF DEATH* was as follows: A

..... Enteritis .....

.....

..... (Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Adolph C. Eisenhofer M. D.

July 22 1920 (Address) 2201 Orleans St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Schwartz Cem.	July 23 1920
20-UNDERTAKER	ADDRESS
Philip Henrig	2016 Orleans

N.B.—Every item of information should be carefully supplied. AGE should be stated [illegible]. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D45028

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45028

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child's Hospital St.; 18 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Wilkerson

(Residence in Baltimore: No. Nursery & Child's Hospital St.; ..... yrs., 6 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	

6-DATE OF BIRTH, Dec. (Month) 27 (Day), 1919 (Year)

7-AGE, ...yrs. 6 mos. 25 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER Mary Elizabeth Wilkerson

13-BIRTHPLACE OF MOTHER (State or Country), North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss G. Hutton

(Address) Nursery & Child's Hospital

15-

Filed JUL 23 1920, 191.....

G. H. [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 14 1920, to July 22 1920, that I saw her alive on July 22 1920, and that death occurred, on the date stated above, at 11:45 P.m.

The CAUSE OF DEATH* was as follows:

Acute Ileo-Colitis

..... (Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Malnutrition

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Singleton M. D.

July 23, 1920 (Address) 2002 E Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	July 25 1920

20-UNDERTAKER	ADDRESS
Geo. H. Smith	2002 E Pratt St

N. B.—Every item of information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr. Norris

2 45029

CERTIFICATE OF DEATH.

1920 45029

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Donahue.

(a) RESIDENCE. No. 327 Yale ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH CARE. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 5 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	~~27~~ 30	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk. 209

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER James F. Donahue

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Laura Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant University Hospital Records
(Address)

15 Filed July, 19 20 JUL 22 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21st 1920

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1920, to July 21, 1920, that I last saw him alive on July 21, 1920 and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Acute pyelonephritis, acute cystitis.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urological Examination

(Signed) Cyrus F. Norris, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	7/24/1920

20 UNDERTAKER George H. Fraley ADDRESS Fulton & Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D450 30 ✓ 1042 D45030

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 306 S. Washington ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Mada

(a) RESIDENCE. NO. 306 S. Washington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH INK. ALL INFORMATION should be carefully supplied. AGE should be stated EXACTLY. Information should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Feb 12 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Adam Mada

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Stachowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Adam Mada
(Address) 306 S Washington

15 Filed JUL 23 1920 19 G. H. Gresh Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1920

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1920, to July 23, 1920, that I last saw h alive on July 23, 1920, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Gillis Cretin.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) William J Rennett M. D.

7/23 19 (Address) 801 n Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	7/24 1920
20 UNDERTAKER	ADDRESS
Wm Gaertner & Co	1618 Eastern ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45031

D 45031

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 20 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tony Condiotis

(Residence in Baltimore: No. 25 74 W Fairmount Ave St.; 7 yrs.. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. Feb 16, 1893 (Month) (Day) (Year)

7-AGE. 27 yrs. 5 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER. San Condiotis

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Josepine Lombardo

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Baltimore

15-

Filed JUL 23 1920 G. F. G. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 22, 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20, 1920, to July 22, 1920, that I saw him alive on July 22, 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis (Pulmonary)

(Duration) 4 yrs. 4 mos. 7 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Intestines

(Duration) 4 yrs. 10 mos. 7 ds.

(Signed) Louis Sachs M. D.

July 22, 1920. (Address) The Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 2 ds. In the State 7 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 2574 W Fairmount Ave

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, July 24, 1920.

20-UNDERTAKER Jack Lewis ADDRESS 1411 E. Balto

Spec.—8-24-14—M. & T.—2000 Bks.

D45032

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45032

CERTIFICATE OF DEATH.

REGISTERED NO. C 5H

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 N. Lamar ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dan Riggle

(Residence in Baltimore: No. 130 N. Lamar St.; 46 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. November 18, 1874 (Month) (Day) (Year)

7-AGE 46 yrs. 6 mos. 3 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Actor
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country) Prince George Co Md.

PARENTS.

10-NAME OF FATHER. Arch Riddle

11-BIRTHPLACE OF FATHER (State or Country) P G Co Md

12-MAIDEN NAME OF MOTHER Elizabeth Wall

13-BIRTHPLACE OF MOTHER (State or Country) P G Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Dan Riggle

(Address) 130 N Lamar St

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH July 21, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1915 1915, to July 21 1920, that I saw h[illegible] alive on July 21 1920, and that death occurred, on the date stated above, at 7.50 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Influenza

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) F. D. Lambert M. D.

7-21, 1920 (Address) 211 N. Lamar

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Druid Ridge Cem

DATE OF BURIAL. July 23, 1920

20-UNDERTAKER H. W. Kenton

ADDRESS 230 N Howard

N. B.—Every item of information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45033 ✓ 42D 45033

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3855 Imany Ave ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Carlin

(a) RESIDENCE. No. 3855 Imany ST., 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Carlin 1866

6 DATE OF BIRTH (month, day, and year) April 24.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Co. Md.

PARENTS

10 NAME OF FATHER Isaac Berkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Matty Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Co

14 Informant Frank Carlin (Address) 3855 Imany Ave

15 Filed JUL 23 1920 19 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-21 1920

17 I HEREBY CERTIFY, That I attended deceased from May 15 1920 to July 21 1920.

that I last saw h alive on July 20 1920.

and that death occurred, on the date stated above, at 4. 30/4 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ulceration of Uterus

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Palpation

(Signed) C. F. Longden M. D.

7-21 1920 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	July 23 1920

20 UNDERTAKER Chenoweth Son ADDRESS Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S CERTIFICATE should be stated EXACTLY. Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION of deceased should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45034

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

402 45034

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1836 N. Spring ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Scott

(a) RESIDENCE. NO. 1836 N Spring ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20. 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wash D C

PARENTS

10 NAME OF FATHER James H Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER May Clemons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Clemons
(Address) 1705 Ashland Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1920

17 I HEREBY CERTIFY, That I attended deceased from May 25 1920 to July 20 1920.
that I last saw him alive on July 19 1920,
and that death occurred, on the date stated above, at 8:15 p m.
The CAUSE OF DEATH* was as follows:

Ulcer of Stomach
& Pylorus 0074

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic interstitial Nephritis
(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas H Scott M D.

(Address) 1520 Monument St

7/20/20

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md	July 23rd 1920

20 UNDERTAKER ADDRESS

Mrs Elliott 1705 Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45035

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45035

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Tilghman 5 — REGISTERED NO. 28

CITY OF BALTIMORE: (No. 1225 Jefferson St.: Ward) — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Tilghman

(a) RESIDENCE. No. 1225 Jefferson St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Julia Tilghman

6 DATE OF BIRTH (month, day, and year) — 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	—	—

8 OCCUPATION OF DECEASED live in

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer none at present

9 BIRTHPLACE (city or town) (State or country) live in Baltimore 39 years Easton, Md

PARENTS

10 NAME OF FATHER William Tilghman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Easton Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Julia Tilghman
(Address) 1225 Jefferson st

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1920

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1920, to July 20, 1920, that I last saw him alive on July 16, 1920, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows: Phthisis of larynx

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto - Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. H. C. Robinson, M. D.

(Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 23 1920
20 UNDERTAKER Mrs Root & Elliott	ADDRESS 1735 Eutaw

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. PHYSICIAN'S CERTIFICATE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE

Spec.—6-9-19—H. P. Co.—1000 Bl.

D-45036

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 D45936

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2105 Huntingdon Ave ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Pauline Pearl.

(a) RESIDENCE. No. 2105 Huntingdon Ave WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 11 hours How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, 11 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Oscar Lee Pearl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick County, Md.

12 MAIDEN NAME OF MOTHER Amanda L. Patton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick County, Md.

14 Informant Oscar L. Pearl
(Address) 2105 Huntingdon Ave.

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1920

17

I HEREBY CERTIFY, That I attended deceased from July 21, 1920, to July 22, 1920, that I last saw h.. alive on July 21, 1920, and that death occurred, on the date stated above, at 10 20 A m.

The CAUSE OF DEATH* was as follows:

Premature foetus (5 months)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lawrence G. Miller, M. D.

, 19 (Address) 14 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	7/22 1920
20 UNDERTAKER	ADDRESS
Merrill Mears & Son	805 N. Calvert

N. B.—Words printed in italics should be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. Exact statement of OCCUPATION should be given so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45037

CERTIFICATE OF DEATH.

150 D 45037

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margery Davidson

(a) RESIDENCE. NO. 3920 Park Heights Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. Information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work X

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer X

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Spencer C. Davidson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Marie Phelan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs. Bessie Davidson
(Address) 3920 Park Heights Ave

15 Filed JUL 23 1920 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-23 1920

17 I HEREBY CERTIFY, That I attended deceased from 7-17, 1920, to 7-22, 1920,

that I last saw h[illegible] alive on 7-22, 1920,

and that death occurred, on the date stated above, at 11.55 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction (congenital)

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Zeb. V. Hooper, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	7/24 1920
20 UNDERTAKER J. Fahey Sons	ADDRESS 13 E Eighth St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45038 HEALTH DEPARTMENT—CITY OF BALTIMORE D45038

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2304 E Biddle St.; 8 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Leslie Mason

(a) RESIDENCE. No. 2304 E Biddle St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 19, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Samuel L. Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Rosa Gantz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant E. L. Mason
(Address) 2304 E. Biddle St

15 Filed JUL 23 1920 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1920

17 I HEREBY CERTIFY, That I attended deceased from July 14th, 1920, to July 22, 1920.

That I last saw him alive on July 22nd, 1920.

and that death occurred, on the date stated above, at 4.40 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Entero-colitis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Poulton, M. D.

7/24/1920 (Address) 654 Columbia Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	July 24 1920
20 UNDERTAKER	ADDRESS
Burkert & Jenkler	1739 Eager

N. B.—Blanks must be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Aug 27 039

HEALTH DEPARTMENT—CITY OF BALTIMORE

L 45039

CERTIFICATE OF DEATH.

14-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Watsen Argolas

(a) RESIDENCE. NO. 4308 Fifth St. Baltimore Md WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 25 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) 900

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Matthew Argolas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Lillian White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J. Hutt. Brends
(Address)

15 Filed JUL 23 1920 ROBERT A KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1920

17

I HEREBY CERTIFY, That I attended deceased from July 14. 1920, to July 22 1920, that I last saw h[illegible]live on July 22, 1920, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Stool culture

(Signed) Harold L. Hopkins M. D.

7/22 1920 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem.	July 24 1920
20 UNDERTAKER	ADDRESS
Lilly & Zeiler.	402 S Mo[illegible]

N. B.—WRITE LEGIBLY. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1045040

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045040

CERTIFICATE OF DEATH.

172

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2500 Maryland Ave ST. ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ann Moulton

(a) RESIDENCE. No. 2500 Maryland Ave ST. ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John D. Moulton

6 DATE OF BIRTH (month, day, and year) Nov 27-1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER William Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland. ?

12 MAIDEN NAME OF MOTHER Ellen Walsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland. ?

14 Informant F Howard Kidd

(Address) 2500 Maryland Ave.

15 Filed JUL 23 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1920

17 I HEREBY CERTIFY, That I attended deceased from July 14 ... 1920 ... to July 22 ... 1920 ... that I last saw h alive on July 20 ... 1920 ... and that death occurred, on the date stated above, at 10:45 a m.

The CAUSE OF DEATH* was as follows:

Surgical Shock following Accident Impacted Fracture mid ½ right Femur

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Senile Cardiac Debilation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No ... Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Robert L. Caldwell ... M. D.

July 23. 1920 (Address) 2117 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	July 24 1920
20 UNDERTAKER	ADDRESS
E A Wendefeld Jr	Green St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. ... mation should be carefully supplied. AGE should be ... CAUSE OF DEATH in plain terms, so that it may be pr... TION is very important. See instructions on back of cer...

Spec.—8-24-14—M. & T.—2000 Blks.

D45041

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45041

CERTIFICATE OF DEATH.

6-091

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 419 W 28th St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lentine Nicholson

(Residence in Baltimore: No. 419 W 28th St., St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept (Month) 17 (Day), 1917 (Year)

7-AGE, ...yrs. 10 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Walter McNicholson

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER, Gladys Henson

13-BIRTHPLACE OF MOTHER (State or Country), Carroll Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gladys Nicholson

(Address) 419 W 28th St

15- JUL 23 1920 Filed, 191. ROBERT N KRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 14 1920, to July 22 1920, that I saw h.er alive on July 22 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Measles

(Duration) ....yrs. ....mos. 9 ....ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(Duration) ....yrs. ....mos. 3 ....ds.

(Signed) C. Loring Jaslin M. D.

July 22, 1920 (Address) 1330 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, July 24, 1920

20-UNDERTAKER, E. A. Bradley — ADDRESS Green Md

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY WITH INK.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45042 HEALTH DEPARTMENT—CITY OF BALTIMORE D45042

CERTIFICATE OF DEATH. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 N. Linwood ave ~~St.~~; 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael F. Cooney

(a) RESIDENCE. NO. 21 N. Linwood ave. 6 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	39	3		

8 OCCUPATION OF DECEASED .03

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Patrick Cooney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire.

12 MAIDEN NAME OF MOTHER Mary Early

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant May Cooney (Address) 21 N. Linwood ave

15 Filed JUL 23 1920 ROBERT B. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1920

17 I HEREBY CERTIFY, That I attended deceased from June 5 1920, to July 20 1920, that I last saw h. alive on July 20 1920, and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam

(Signed) B. Kelly, M. D.

, 19 (Address) 100 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	July 24 1920
20 UNDERTAKER J. A. Moran	ADDRESS 300 E. Baltimore

N.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45043

1045043

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 120

1-PLACE OF DEATH South Balto. General Hos. ST.: 16 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Clara C. Ringer

(a) RESIDENCE. NO. 1031 N Fulton Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of widow.

6 DATE OF BIRTH (month, day, and year) Sept 16 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Jacob Linne

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Mary Dunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant H. E. Ringer

(Address) 1031 N Fulton av

Filed JUL 23 1920 ROBERT B. LAUTER Registrar

Veja Booker [illegible] H. E. Ringer.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/23 1920

17 I HEREBY CERTIFY, That I attended deceased from 7/16 1920, to 7/23 1920

that I last saw her alive on 7/23 1920,

and that death occurred, on the date stated above, at 9.50 m.

The CAUSE OF DEATH* was as follows:

Renal disease

Chronic nephritis.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

Bronchitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. C. Dorbal. M. D.

19 (Address) S Balto Gen Hos.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Reedyville Wash Co Md	July 26 1920

20 UNDERTAKER Woodcock & Horstkamp ADDRESS

N. B. [illegible] should be carefully supplied. AGE should be stated EXACTLY. Information should be properly classified. Exact statement of OCCUPATION of DECEASED and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045044

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 1045044

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 163 Montebello Ave. ST.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. West.

(a) RESIDENCE. NO. 163 Montebello Ave. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry J. West

6 DATE OF BIRTH (month, day, and year) March 17 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles Town W. Va.

PARENTS

10 NAME OF FATHER Paul Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Ann Kane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Harry J. West (Address) 163 Montebello Ave

15 Filed JUL 23 1920 ROBERT B. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 20

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 1920, to July 22 1920, that I last saw h[illegible] alive on July 7 1920, and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 2 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of — —

Was there an autopsy? —

What test confirmed diagnosis? T.B. Sputum & Clinical

(Signed) J. C. [illegible], M. D.

(Address) 1436 Bray

*(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: July 24 1920

20 UNDERTAKER: New Cork — ADDRESS: N. Gay

mation should be carefully supplied. Name should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045045

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045045

CERTIFICATE OF DEATH.

93

REGISTERED NO. 27

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Guy Miller

(a) RESIDENCE. No. 5320 Denmore Ave. ST., WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Addie Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant: Hospital Records (Address) M.T.H.

15 Filed JUL 23 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1917, to July 22, 1920, that I last saw him alive on July 22, 1920, and that death occurred, on the date stated above, at 10.15 a.m.

The CAUSE OF DEATH* was as follows: Over

Chronic empyema

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Lung puncture

(Signed) L. J. Rigney, M. D.

7-22-1920 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bethlehem Cemetery DATE OF BURIAL July 25 1920

20 UNDERTAKER Wm Cahoon & Roth Co ADDRESS

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Run over by wagon which caused empyema 12 yrs ago. Not tuberculous. Operated on at Md. Gen. for empyema.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045046

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045046

104

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2417 Fleet ST.: 1 st. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Giza,

(a) RESIDENCE. NO. 2417 Fleet ST., 1 st. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female,	White,	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb-25-1920,

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.,

PARENTS

10 NAME OF FATHER Joseph Giza,

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland,

12 MAIDEN NAME OF MOTHER Frances Staniecz,

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Md.,

14 Informant Frances Giza, (Mother)
(Address) 2417 Fleet Street

15 Filed JUL 23 1920 19 ROBERT B. LEAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1, 20 1920 to July 23, 1920.

that I last saw h[illegible] alive on July 23, 1920.

and that death occurred, on the date stated above, at 240 A— m.

The CAUSE OF DEATH* was as follows:

Delio Cardiac Paralysis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) [illegible]

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. D. Gyson M. D.

7/23/20 (Address) 80 Linwood Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	July 24 1920
20 UNDERTAKER	ADDRESS
M. F. Sadowski.	708 S. Ann

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be stated in years, months and days. Exact statement of information should be given as to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45047

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45047

CERTIFICATE OF DEATH.

151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 Fleet ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Symski,

(a) RESIDENCE. NO. 1816 Fleet ST., 2- WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male,	White,	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 20-1920.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child, 100

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.,

PARENTS

10 NAME OF FATHER Michael Symski,

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland,

12 MAIDEN NAME OF MOTHER Frances Lachenska,

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland,

14 Informant Frances Symska, (Mother)
(Address) 1816 Fleet Street

15 Filed JUL 23 1920 ROBERT E. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUL 23 1920

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1920, to July 23, 1920, that I last saw him alive on July 22, 1920, and that death occurred, on the date stated above, at 5.15 A. m.

The CAUSE OF DEATH* was as follows:

Bronchitis (acute)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Lack of Nutrition

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John H. Rehberger, M. D.

, 19 (Address) 1709 Alice Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	July 24" 1920
20 UNDERTAKER	ADDRESS
M. F. Sadowski.	705 S. Ann

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of DECEASED'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DECEASED'S OCCUPATION is very important. See instructions on back of certificates.

D45048 HEALTH DEPARTMENT—CITY OF BALTIMORE D45048

CERTIFICATE OF DEATH. 158

1-PLACE OF DEATH
CITY OF BALTIMORE (No Roosevelt Park Hampden 13 ST. WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Angie Mikall

(Residence in Baltimore: No. 1536 Baldwin st St.; 10 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If less than one day, hours or minutes. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): married

6-DATE OF BIRTH: Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, 54 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country): MD

PARENTS.

10-NAME OF FATHER: John Nell

11-BIRTHPLACE OF FATHER (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Mikall

(Address) 1536 Baldwin st

15- Filed JUL 23 1920, 191..... ROBERT P. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 23, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Thornton M. D.
(Coroner.)

July 23 (Date) 763 N. Roland (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Rohrersville Md. DATE OF BURIAL, July 26 1920

20-UNDERTAKER Greenwell & Son ADDRESS Hagerstown

Spec.—6-9-19—H. P. Co.—1000 Bks.

2045049 HEALTH DEPARTMENT—CITY OF BALTIMORE 2045049

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1436 N. Bond St ST.: 8 WARD)

2-FULL NAME Anna Rebecca McCleary.

(a) RESIDENCE. No. 1436 N Bond ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug 13 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
70.	70	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Noah A Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Kate Banks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant George E McCleary
(Address) 1436 N Bond St

15 Filed JUL 23 1920 19 ROBERT R. PRAETER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1920

17 I HEREBY CERTIFY, That I attended deceased from July 20 1920 to July 23 1920 that I last saw her alive on July 22 1920 and that death occurred, on the date stated above, at 1230 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arteriosclerosis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urinary Analysis.

(Signed) C. H. Cook M. D.

19 (Address) 1501 N Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	July 26 1920
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1944

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. Exact statement of decedent's age at last birthday is required. Information should be carefully supplied. AGE should be properly classified. Exact statement of decedent's age at last birthday is required. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of decedent's age at last birthday is required. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045050 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045050

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 738 W Lexington St.: 4 WARD) REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jay Green

(a) RESIDENCE. No. 738 W. Lexington St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 10 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of ~~[illegible]~~ Lillie M. Green.

6 DATE OF BIRTH (month, day, and year) Sept 4 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) House

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Milton Wesley Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sophia Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Lillie M. Green

(Address) 738 W. Lexington St.

15 Filed JUL 23 1920 ROBERT E. LEATHERBURY Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1920

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1920, to July 23, 1920, that I last saw him alive on July 22, 1920, and that death occurred, on the date stated above, at 10:35 a. m.

The CAUSE OF DEATH* was as follows:

Hypertrophic Cirhosis of Liver

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? not needed

(Signed) Chester Riland., M. D.

7-23 1920 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: July 24 1920

20 UNDERTAKER Harry W. Ehlen — ADDRESS 1544 W. North Ave

Should be carefully supplied. AGE ... it may be properly classified. Exact statement of ... on back of certificates.

CAUSE OF DEATH in plain terms, so that it ma...

TION is very important. See instructions on ba...

1045051 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045051

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.) 8 WARD)

2-FULL NAME Eberle Steiner

(Residence in Baltimore: No. 2427 E. Monument St.: 57 yrs., 7 mos. 2 ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, December 20th, 1869 (Month) (Day) (Year)

7-AGE, 57 yrs. 7 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer): 089

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Chas Steiner

11-BIRTHPLACE OF FATHER (State or Country), Washington D. C.

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country), ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Steiner

(Address) 2427 E. Monument St.

15- Filed JUL 23 1920 191... ROBERT J KRAUTER Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 22, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism - following amputation of leg - thru Followed Varicose Ulcers — yrs. 4 mos. 1 ds.

CONTRIBUTORY (Secondary) Followed accidentally

Shrinkage Coagulation Against Sleep mos. ds.

(Signed) M. D. (Coroner.)

July 23, 1920 (Address) 1627 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 10 days yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem — DATE OF BURIAL, July 24 1920

20-UNDERTAKER Russ & Miller — ADDRESS 2334 Jefferson St

N. B.—Every item of information should be carefully supplied. Accuracy is important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45052 HEALTH DEPARTMENT—CITY OF BALTIMORE D45052

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 W. Barre ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenneth Robert Funk

(a) RESIDENCE. No. 813 Barre ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	-	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER George Funk

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Bernice Ferree

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Geo E. Funk
(Address) 813 Barre St

15 Filed JUL 23 1920 19 ROBERT K KRAUTHOFF Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1920

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1920, to July 22, 1920, that I last saw h.. alive on July 22, 1920, and that death occurred, on the date stated above, at 6 30 P. m. The CAUSE OF DEATH* was as follows:

Gastroenteritis acute

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy? ..... no

What test confirmed diagnosis?

(Signed) A. H. A. Mayer, M. D.

7-22, 1920 (Address) 2438 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	July 24 1920

20 UNDERTAKER Wm J Fickus & Son ADDRESS Norfolk Va

...mation should be carefully supplied. Avoid it may be properly classified. Leave CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45053 ✓ 64 D45053

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 424 Pine St ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mandy Fenny

(Residence in Baltimore: No. 424 Pine St St.(-) ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	col.	widow

6-DATE OF BIRTH, ? (Month) ? (Day) 1853 (Year)

7-AGE, 67 yrs. ... mos. ... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Domestic

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Buchanan

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Felix Frye

(Address) 102 E. Hubert St

15-

Filed JUL 24 1920 G. H. Grese Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 21 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 14 June 1920, to 21 July 1920, that I saw h[illegible] alive on 20 July 1920, and that death occurred, on the date stated above, at 0.22 p.m.

The CAUSE OF DEATH* was as follows:

Cellulitis - Erysipelas

Seven weeks

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis a Fed months

(Duration) ....yrs. ....mos. ....ds.

(Signed) Edwin Field Pope M. D.

22/7/, 1920 (Address) 424 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hillsboro County — DATE OF BURIAL, July 24, 1920

20-UNDERTAKER Felix B Frye — ADDRESS 102 E Hubert St

N. B.—Every item of information should be carefully considered, that it may be properly classified. EARLY information of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45054 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45054

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 Cider alley ST. 22 64 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Boyer

(a) RESIDENCE. NO. 616 Cider alley ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colred	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Boyer

6 DATE OF BIRTH (month, day, and year) [illegible] 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 100

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rust Co. (State or country) Md

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Mary Boyer (Address) 616 Cider alley

15 Filed JUL 24 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22- 1920

17 I HEREBY CERTIFY, That I attended deceased from 2-2-, 1920, to 7-22-, 1920.

that I last saw him alive on 7-21-, 1920,

and that death occurred, on the date stated above, at 11,30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary) Arteria-sclerosis indefinate

(duration) [illegible] yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M. H. Carey M D, M. D.

7-22-1920 (Address) 611 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion — DATE OF BURIAL July 25 19

20 UNDERTAKER J. H. Toadvine — ADDRESS 142 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 45055 ✓ D 45055

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 Lindenhall ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Brown

(Residence in Baltimore: No. 915 Lindenhall St.: 40 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH. July 4, 1864
(Month) (Day) (Year)

7-AGE. 56 yrs. ..... mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). 070

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm Brown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER Roanna Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Jenkins

(Address) 915 Lindenhall St

15- Filed JUL 24 1920, 191... G. H. Cress Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 11 1920, to July 21 1920, that I saw her alive on July 20 1920, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Contributory Unknown

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. E. Bonsall M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn — DATE OF BURIAL, July 24, 191...

20-UNDERTAKER John H. Toadvine — ADDRESS 142 Custer St

N.B.—Every item of information should be carefully supplied. Cause of CAUSE OF DEATH in plain terms, so that it may be properly classified. Care important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

45056

HEALTH DEPARTMENT—CITY OF BALTIMORE

45056

CERTIFICATE OF DEATH.

82-091

REGISTERED NO. 26

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Donak or Douch

(a) RESIDENCE. No. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records.

(Address) New City Hospital.

15 Filed JUL 24 1920 G. H. Gres Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1920. to July 22, 1920.

that I last saw him alive on July 22, 1920.

and that death occurred, on the date stated above, at 2:45 P. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis with cerebral thrombosis.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 3. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) V. B. Eoman, M. D.

7/23/1920 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem. Dark Hill Cem.	July 26 1920

20 UNDERTAKER ADDRESS

Jos. J. Herr 156 N. Linzaw ave.

Note—Information should be carefully supplied. All questions should be properly classified. Exact information may be required. Do not use abbreviations. Information should be carefully supplied. All questions should be properly classified. Exact information may be required. Do not use abbreviations. CAUSE OF DEATH in plain terms, so that it may

Spec. 6-9-19 H. P. Co.—1000 Blks.

D 45057

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45057

CERTIFICATE OF DEATH.

REGISTERED NO. 104

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 923 N Bradford St.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Geo Slifka

(a) RESIDENCE. No. 923 N. Bradford St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 17 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 23/20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		17		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer): School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER John Slifka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore City

12 MAIDEN NAME OF MOTHER Anna Rady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant John Slifka
(Address) 923 N Bradford St

15 Filed JUL 24 1920 C. H. Greer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1920

17 I HEREBY CERTIFY, That I attended deceased from July 22. 1920. to July 24. 1920.
that I last saw him alive on July 24. 1920.
and that death occurred, on the date stated above, at 3:30 a. m.
The CAUSE OF DEATH* was as follows:

Acute Glomerulitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Acidosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) J. Fred. Ruppert M. D.

7-24 1920 (Address) 8004 Belair Rd Govt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 26 1920

20 UNDERTAKER Frank Enoch & Sons ADDRESS

Be sure that each question is properly answered. AGE should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 45058 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45058

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE: (No. 567 W Fredrick ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Wallace

(Residence in Baltimore: No. 567 W Fredrick St.; ..... yrs., ... mos., ... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: May 4th, 1886 (Month) (Day) (Year)

7-AGE: 34 yrs. 2 mos. 18 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): Private

9-BIRTHPLACE, (State or Country): Balto, Md

PARENTS.

10-NAME OF FATHER: John Bedford

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Harriet Gray

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Mary Gray

(Address): 567 W Fredrick

15-

Filed....., 191.....

Registrar.

JUL 24 1920 C. H. C...

N.B.—Every item of information must be given, so that it may be properly classified. Cause of death must be stated in plain terms. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: July 22nd, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 19th, 1920 to July 22nd, 1920, that I saw h— alive on July 22nd, 1920 and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory

(Duration) ..... yrs. 4 mos. ..... da.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. ..... da.

(Signed) A. Ker Ellis M. D.

July 22, 1920 (Address) 924 N Monday

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: July 24, 1920

20-UNDERTAKER: S. L. Brown & Son — ADDRESS: 818 W. Monday St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D45059 ✓ D45059

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1710 Park Ave 11 St.; WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary H. Ross

(Residence in Baltimore: No. 1710 Park Av. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, December 1838
(Month) (Day) (Year)

7-AGE. 90 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Nurse
(b) General nature of industry, business, or establishment in which employed (or employer). Own

9-BIRTHPLACE, (State or Country), Balto, Md

PARENTS.

10-NAME OF FATHER, Henry Ross

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rachel Rotman

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rachel Ehrlich

(Address) 1710 Park Ave

15-

JUL 24 1920 191

G. H. Grape, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH July 23rd 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from July 1918 191, that I saw h[illegible] alive on July 23 1920 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cerebral Hemorrhage 3 days

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Stroke

(Duration) yrs. mos. ds.

(Signed) A. Friedenwald M. D.

7/24 1920 (Address) 32 W. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, July 24th 20.

20-UNDERTAKER Samuel Ebersberg

ADDRESS 978 N. Eddie

N. B.—Every item of information should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45060 — D 45060

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 200 E. Washington ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hand

(a) RESIDENCE. NO. 200 E. Washington ST., 2 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 hrs. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 23, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) — 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Leon Sylvanus Hand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Helen Lingelbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Leon S. Hand
(Address) 200 E. Washington St

15 Filed AUG 24 1920 19.....

G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1920

17 I HEREBY CERTIFY, That I attended deceased from July 23. 1920. to July 23. 1920.
that I last saw him alive on July 23. 1920
and that death occurred, on the date stated above, at 6 7 45 p. m.
The CAUSE OF DEATH* was as follows:

(Premature birth (5th month.)

(duration) ..... yrs. ..... mos. 2 hrs

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emil Hennig M. D.

, 19 (Address) 1062 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	July 24 1920
20 UNDERTAKER Philip Hennig	ADDRESS 2016 Orleans

mation should be careful, legible. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45061

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45061

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 200 S. Washington ST.; V WARD)

2-FULL NAME Baby Hand

(a) RESIDENCE. No. 200 S. Washington ST., V WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. 2 hrs. ... ds. • How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years ... Months ... Days ... If LESS than 1 day, 2 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md
(State or country)

PARENTS

10 NAME OF FATHER Leon Gilmans Hand

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Helen Engelbach

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Leon S. Hand
(Address) 200 E. Washington St.

15 Filed JUL 24 1920, 19... G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1920, to July 23, 1920, that I last saw h alive on July 23, 1920 and that death occurred, on the date stated above at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Amateur birth (5-6 mos)

(duration) ... yrs. ... mos. 2 hrs.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Basil S. Kreuglen M.D.

, 19 (Address) 2002 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: July 24 1920

20 UNDERTAKER: Philip Hermig

ADDRESS 206 Orleans

CAUSE OF DEATH is plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 45062

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 45062

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital (St.) (16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Opie

(a) RESIDENCE. No. 730 Calhoun St. St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1876 (?)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44 (?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm. Opie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address) M.T.H.

15 Filed JUL 24 1920 Registrar G. H. Gross.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1920

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1920, to July 22, 1920, that I last saw her alive on July 21, 1920, and that death occurred, on the date stated above, at 5.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum.

(Signed) L.J. Pingrey, M. D.

7-22-20, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel entry	July 26, 1920
20 UNDERTAKER	ADDRESS
Mrs Robt a Elliott	1725-Hanley Av

mation should be carefully examined, so that it may be properly classified. Exact statement of occupa-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-
TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 45063 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45063

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 Druid Hill ave St. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Patterson

(a) RESIDENCE. No. 410 Druid Hill ave St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) January 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER Peter Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Kelly

(Address) 410 Druid Hill ave

15 Filed JUL 24 1920 C. H. Circa Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1920

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1920, to July 21, 1920, that I last saw her alive on July 21, 1920, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas F Blanton M. D.

July 22, 1920 (Address) 150 N McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	July 24 1920
20 UNDERTAKER Mrs Robt a Elliott	ADDRESS 1725 Ashland Ave

mation should be carefully supplied. Exact statement of facts CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45064 HEALTH DEPARTMENT—CITY OF BALTIMORE D45064

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital Col. Mall REGISTERED NO.....

CITY OF BALTIMORE: (No Calvert & Saratoga ST. Bed 4 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Dill

(a) RESIDENCE. NO. Queenstown Md ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie Dill

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queenstown Md

PARENTS

10 NAME OF FATHER Joseph Dill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Darcy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant From History (Address)

15 Filed ..... 19 JUL 24 1920 G. H. Gr... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1920

17 I HEREBY CERTIFY, That I attended deceased from June 24 1920, to July 22 1920, that I last saw him alive on July 22 1920, and that death occurred, on the date stated above, at 9:20 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Unknown yrs. ds.

CONTRIBUTORY (Secondary) Miliary Tuberculosis Tuberculous Meningitis and/or the adrenals (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Anatomical Pathology

(Signed) W. S. Carr, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Centerville Md	Jul 24 1920
20 UNDERTAKER Dame Easton	ADDRESS 916 Eutaw

mation should be carefully supplied. Exact statement of occupa... may be properly classified. Also that it may be known whether CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

45065 HEALTH DEPARTMENT—CITY OF BALTIMORE 45065

CERTIFICATE OF DEATH.

X 532

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard & Kelly Hospital St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence A Barnett

(Residence in Baltimore: No. Howard & Kelly Hosp St. St.; 0 yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 40 yrs. ..... mos. ..... ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Book keeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Downing, Alabama

PARENTS.

10-NAME OF FATHER, A. L. Barnett

11-BIRTHPLACE OF FATHER (State or Country), Alabama

12-MAIDEN NAME OF MOTHER Susie Sherman

13-BIRTHPLACE OF MOTHER (State or Country), Alabama

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rufus Barnett

(Address) Mitchells Ala

15-

Filed JUL 24 1920 G. H. Grese. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 23, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 21 1920, to July 23 1920, that I saw h living alive on July 23 1920, and that death occurred, on the date stated above, at 11:45 P m.

The CAUSE OF DEATH* was as follows:

Leukemia

(Duration) 2 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dudley A. Robinson M. D.

July 23, 1920 (Address) 1418 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 5 ds. In the State — yrs. 1 mos. ..... ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence Hartford Alabama

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Montgomery Ala	July 24 1920
20-UNDERTAKER	ADDRESS
Chas. S. Black	142 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. All important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45066 HEALTH DEPARTMENT—CITY OF BALTIMORE D45066

CERTIFICATE OF DEATH.

REGISTERED NO. 2129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 429 W Hamburg ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Jennie Mary Bethea

(a) RESIDENCE. NO. 429 W Hamburg ST., WARD. 21

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): D.C.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): D.C.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Wm Bevans

(Address) 429 W Hamburg

15 Filed JUL 24 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1920

17 I HEREBY CERTIFY, That I attended deceased from July 7th, 1920, to July 22nd 1920, that I last saw h alive on July 22nd 1920, and that death occurred, on the date stated above, at 10.30a m.

The CAUSE OF DEATH* was as follows: over

Acute Peritonitis (duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Colonic Infection probably typhoid (duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. Guy Bowley M. D

7/27/19 20 (Address) 908 Shaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pt Auburn Cemetery	7/24 1920
20 UNDERTAKER	ADDRESS
Jas Geo H Hooper	406 E Camden St

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DECEASED'S OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45067

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45067

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1250 James St. St.; 21 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Schmidl

(a) RESIDENCE. No. 1250 James St St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 5 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 24 1920

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Schmidl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Minnie Doran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs Charles Schmidl

(Address) 1250 Columbia Ave

15 Filed JUL 24 1920 E. H. Cress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1920

17

I HEREBY CERTIFY, That I attended deceased from July 15, 1920, to July 23, 1920, that I last saw him alive on July 20, 1920, and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Stanley J Hoag, M. D.

7/24 1920 (Address) 729 Columbia ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	July 24 1920
20 UNDERTAKER	ADDRESS
John Doran & Son	901 Hollins

mation should be correctly supplied. Exact statement of occupa
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D45068

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D45068

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1914 Lemmon ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Ella Shoffer

(Residence in Baltimore: No. 1914 Lemmon St. St.; yrs., 5 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, Feb. 3 (Month) (Day), 1920 (Year)

7-AGE, yrs. 5 mos. 19 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Howard L. Shoffer

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Ella H. Hill.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard L. Shoffer

(Address) 1914 Lemmon st.

15-

Filed JUL 24 1920, 191.... G. H. Gres Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 17 1920, to July 22 1920, that I saw her alive on July 22 1920, and that death occurred, on the date stated above, at 1250 P m.

The CAUSE OF DEATH* was as follows:

Chronic Infection

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas A Schaefer M. D.

July 22, 1920 (Address) 53 S. Paca St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, July 24, 1920

20-UNDERTAKER Joseph D Cook ADDRESS 1003 W Balto st.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Name of disease alone is not important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45069

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45069

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 646 & 28 ST.; 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosetta Johnson

(a) RESIDENCE. NO. 646 & 28 ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 27th 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt md

PARENTS

10 NAME OF FATHER James Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) King Co Va.

12 MAIDEN NAME OF MOTHER Ellen Scott.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) King Co Md

14 Informant (Address) James Johnson 646 E 28th st

15 Filed JUL 24 1920 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1920

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1920, to July 23, 1920.

that I last saw him alive on July 23 1920.

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) P. Garland Schmidt M. D.

July 24 1920 (Address) 1134 E 31st

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery.	July 24 1920
20 UNDERTAKER	ADDRESS
George F. Ruxton	1737 Hayward ave

mation should be carefully supplied. Exact statements of facts may be properly classified. Exact
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45070

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45070

CERTIFICATE OF DEATH.

37

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Josephs Hospital (St.; Colored (Ward)) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tom. Hooper.

(a) RESIDENCE. NO. 104 N. Durham ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word)
Male.	Colored.	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine Hooper.

6 DATE OF BIRTH (month, day, and year): 1889.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
34	~~dy~~	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer): General.

(c) Name of employer: ———

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant ... (Address) 104 N. Durham. Josephine Hooper.

15 Filed ... 19 ... G. H. Gr... Registrar

JUL 24 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 1920

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1920, to July 22, 1920, that I last saw h.im alive on July 19, 20, 21, 22 1920, and that death occurred, on the date stated above, at 11:30 P.m.

The CAUSE OF DEATH* was as follows:

Fistula in ano
Syphilis

Unknown (duration) ... yrs. ... mos. ~~...~~ ds.

CONTRIBUTORY (Secondary) Anemia

(duration) 2 yrs. ... mos. 8 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No. Date of ———

Was there an autopsy? No.

What test confirmed diagnosis? Blood & Physical Exam

(Signed) Elbert Wild M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem.	July 24th 1920

20 UNDERTAKER: Harry A. Vodery

ADDRESS: 1210 Orleans St

mation should be entered, ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—2000 Bks.

OVER

D45071

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45071

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4739 Park Heights St.; 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William McCourt

(a) RESIDENCE. No. 4739 Park Heights St., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

14 Informant E. Dillaman
(Address) 4739 Park Heights

15 Filed JUL 24 1920 G. H. Gresse Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1920

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1920, to July 23, 1920, that I last saw h[illegible] alive on July 22, 1920, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Dropsy Dis. of Pancreas
Exhaustion

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) W D Wells, M. D.

, 19 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state: (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
West Philadelphia	July 24 1920

20 UNDERTAKER Daniel Easton ADDRESS 916 Eutaw Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT NAME OF DISEASE is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of
occupation is ve
healthfulness of
question applies
pective of age.
or term on the
Farmer or *Plan*
tect, Locomotive
fireman, etc. Bu
trial employmen
kind of work and
or industry, and
vided for the lat
when needed. A
mill; (*a*) *Salesm*
Automobile fact
form part of th
"Laborer," "Fo
without more p
Farm laborer, I
home, who are e
only (not paid
salary), may be
or *At home*, and
At school or *A*
report specifical
in domestic ser
Housemaid, etc.
or given up on a
state occupation
from business,
Farmer (*retire*
occupation wha

ALL BUSINESS STRICTLY CASH AND PAYABLE AT THE TIME SERVICE IS RENDERED

REG. No. 4452 D 45071 DR. W. D. WELLS HOURS: 10 TO 12 A. M. 1 TO 8 P. M.

THE CASH DOCTOR

DATE PARK HEIGHTS AND HAYWARD AVENUES

PATIENT'S NAME Ronald Reagan

ADDRESS 1541 Lemon Ave Apt 4 Phone Arlington 81-J

Yes I am willing to make them to be used in my thesis in the event I should have been operated upon for Ruptured Appendix 1941 Nov 24th

Dr. W. D. Wells

Statement of
DISEASE CAUSIN
respect to time
same accepted t
Cerebrospinal
"Epidemic cer
(avoid use of "Group"); *Typhoid fever* (never re-
port "Typhoid pneumonia"); *Lobar pneumonia;*
Bronchopneumonia ("Pneumonia," unqualified, is
indefinite); *Tuberculosis of lungs, meninges, peri-
toneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of
"Tumor" for malignant neoplasms); *Measles;*

; Chronic valvular heart disease;
al nephritis, etc. The contributory
ntercurrent) affection need not be
portant. Example: *Measles* (disease
29 ds.; Bronchopneumonia (second-
r report mere symptoms or terminal
as "Asthenia," "Anemia" (merely
trophy," "Collapse," "Coma,""Con-
ity" ("Congenital," "Senile," etc.),
ustion," "Heart failure," "Hemor-
,""Marasmus,""Old age," "Shock,"
kness," etc., when a definite disease
d as the cause. Always qualify all
; from childbirth or miscarriage, as
ticemia," "PUERPERAL *peritonitis*,"
for which surgical operation was
r VIOLENT DEATHS state MEANS OF
alify as ACCIDENTAL, SUICIDAL, or
s *probably* such, if impossible to
ely. Examples: *Accidental drown-*
railway train—accident; Revolver
homicide; Poisoned by carbolic acid
de. The nature of the injury, as
ll, and consequences (e. g., *sepsis*,
stated under the head of "contribu-
nendations on statement of cause of
by Committee on Nomenclature of
edical Association.)

SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

D 45072 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45072

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 613 Hertenry St ST.) 5-170 WARD)
REGISTERED NO. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfonzo Bishop
(Residence in Baltimore: No. 613 Hertenry St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, Colored
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 49 yrs. mos. ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Helper Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.
10-NAME OF FATHER, James Bishop
11-BIRTHPLACE OF FATHER (State or Country) Eastern Shore Md
12-MAIDEN NAME OF MOTHER Mary Jones
13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary Bishop
(Address) 613 Hertenry St

15-
Filed JUL 24 1920 191 G. H. Gress Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 22nd, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
Investigation find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) Chas. Lyon Duffy M. D.
July 22nd 1920 (Address) 1806 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery
DATE OF BURIAL, July 25 1920
20-UNDERTAKER P. C. Gross
ADDRESS 1405 McElderry

N. B.—Every item of information should be carefully given, as CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co. 1000 Bks.

D45073

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45073

CERTIFICATE OF DEATH.

REGISTERED NO. 25-80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4106 Walrod Ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James F. Doyle

(a) RESIDENCE. No. 4106 Walrod Ave ST., WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 11 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	11	23	

8 OCCUPATION OF DECEASED D31

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bartlett-Hayward

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Jane Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mary E. Doyle
(Address) 4106 Walrod ave

15 Filed JUL 24 1920 A. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1920

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1920, to July 23, 1920, that I last saw h living alive on July 22, 1920, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac paralysis.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) F. C. Parrish. M. D.

7-23, 1920 (Address) 904 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: July 26 1920

20 UNDERTAKER: John J. Fields — ADDRESS: 1200 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Entries must be made in all items. Infinitives may be used. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45074

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 45074

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 S. Bethel ST.: 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wadyslawa Iwanuik

(a) RESIDENCE. NO. 621 S Bethel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ''

6 DATE OF BIRTH (month, day, and year) March 29-20

7 AGE — Years: — Months: 3 — Days: 24 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DEECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): " "

(c) Name of employer: " "

9 BIRTHPLACE (city or town) (State or country): Baltymore

PARENTS

10 NAME OF FATHER: Mat Iwanuik

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Helena

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mat Iwanuik
(Address): 621 S Bethel St.

15 Filed ..., 19...

JUL 24 1920

Registrar C. H. Grese.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1920

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1920, to July 18, 1920, that I last saw h. alive on July 23, 1920, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) A. J. Friedman M. D.

7/24 1920 (Address) 918 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: 7/24 1920

20 UNDERTAKER: Wm Fallsowski

ADDRESS: 168 Eastern ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-0[illegible]—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1420 45075 ✓ X 1082 45075

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dispo Odessios

(a) RESIDENCE. NO. 810 Church St, Norfolk, Va. WARD. Norfolk Va.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Costas Odessios

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	—	—	

037

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Greece
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Greece
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Greece
(State or country)

14 Informant Hospital Record
(Address) J. H. H.

15 Filed JUL 24 1920 Q. H. Gresé Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1920

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1920, to July 23, 1920, that I last saw her alive on July 23, 1920, and that death occurred, on the date stated above, at 11:45 a. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Infarct

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes No Date of July 21-

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. R. Shaw, M. D.

July 24 1920 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	7-24 1920
20 UNDERTAKER	ADDRESS 175
Robt Brooks & Son	Calhoun st

CAUSE OF DEATH in plain terms, so that it may be properly classified. See back of certificates.
TION is very important. See instructions on back of certificates.

Spec.—10-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 45076

REGISTERED NO. D 45076

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin H. Murdock

(a) RESIDENCE. No. Cincinatti, Ohio ST., WARD. Cincinatti, Ohio,
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Minnie Murdock.

6 DATE OF BIRTH (month, day, and year) June 23, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... mins.
	58	1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work President of Printing ink business
(b) General nature of Industry, business, or establishment in which employed (or employer) 886
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cincinatti Ohio.

PARENTS

10 NAME OF FATHER Harry Murdock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nancy Sneed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Hospital Record (Address) J. H. H.

15 Filed JUL 24 1920 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1920

17 I HEREBY CERTIFY, That I attended deceased from July 22, 19..., to July 23, 1920, that I last saw him alive on July 23, 1920, and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Post Mortem Shock.

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Prostatis Long standing.

(duration) 5 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Ohio

Did an operation precede death? Yes. Date of July 20

Was there an autopsy? Yes.

What test confirmed diagnosis? Hemorrhage - Probably not responsible to cause death.

(Signed) ... M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cincinnatti Ohio	July 24 1920
20 UNDERTAKER John O. Mitchell	ADDRESS 1201 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Information on back of certificate. TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Blks.

1045077

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45077

64 D45077.

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806-S-6th ST.: ... WARD)

2-FULL NAME Audrey Kilson

(a) RESIDENCE. NO. 806 S-6th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M-	W-	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Agnes Kilson

6 DATE OF BIRTH (month, day, and year) Feb 24 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	5-	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer) — —
(c) Name of employer — —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS
10 NAME OF FATHER Audrew Kilson
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland
12 MAIDEN NAME OF MOTHER Not known
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Agnes Kilson
(Address) 806 S 6th St

15 Filed JUL 24 1920 C. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 20 19 (6.30 A.M.)

17 I HEREBY CERTIFY, That I attended deceased from July 1- 1920, to July 22 1920
that I last saw him alive on July 22 1920
and that death occurred, on the date stated above, at 6.30 A.M.

The CAUSE OF DEATH* was as follows:

Asterio-Sclerosis.

CONTRIBUTORY (Secondary) Central Hemiplegia (duration) yrs. 2 mos. 1 ds.

18 Where was disease contracted if not at place of death? — — —
Did an operation precede death? — Date of — — —
Was there an autopsy? — — — —
What test confirmed diagnosis? —

(Signed) Geo Clinton Blades, M. D.
July 24 1920 (Address) 143 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Newburgh N.Y.	7/24/1920
20 UNDERTAKER J. A. Moran	ADDRESS 3000 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. Write plainly with pen and ink. Use no abbreviations. Do not state mode of dying, such as heart failure, asphyxia, etc., but the disease or injury which caused it. If from accident, violence, or casualty, state the nature of accident or injury, and whether it occurred while at work. If from a wound, state the character of wound and whether accidental, suicidal, or homicidal. If from childbirth, state whether single or first child, and whether the labor was normal or instrumental. If from disease of women specify whether single, married, or widowed. If from old age, state the principal diseases and contributory causes of infirmity. If from any cause

Spec.—5-24-14—M. & T.—2000 Bks.

B 45078

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

81 B 45078

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1307 Ashland Ave 10 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie R. Norman

(Residence in Baltimore: No. 1307 Ashland Ave. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Oct. (Month) 6. (Day), 1849 (Year)

7-AGE, 70 yrs. 8 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William Doged

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Annie R. Doged

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Smith

(Address) 1733 E. Biddle St.

15-

Filed JUL 24 1920 191..... G. H. Gresse. Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 20th 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 18th 1920, to July 20 1920, that I saw h.. alive on July 18th 1920, and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis (Duration) 2 yrs. ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

July 24 1920 (Address) 1501 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Green Mount	July 26 1920
20-UNDERTAKER	ADDRESS
Joseph Adrens	221 N. Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45079 ✓ D45079

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Loffelhart

(a) RESIDENCE. No. 2118 S. Charles St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Loffelhart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Boltz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed JUL 24 1920 19 G. H. Cresc. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1920

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1920, to July 23, 1920, that I last saw him alive on July 23, 1920, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? X-ray exam.

(Signed) W Stevenson, M. D.

7/23/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	July 26 1920
20 UNDERTAKER	ADDRESS
George J Rutt	1735 Hayd[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

45080

HEALTH DEPARTMENT—CITY OF BALTIMORE

45080

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 S. Curley St. ST.; 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna McCormick

(a) RESIDENCE. No. 902 S. Curley St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carlton McCormick

6 DATE OF BIRTH (month, day, and year) May 4-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Zoblein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Emma Gobel.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pittsburgh Pa.

14 Informant (Address) Carlton McCormick 902 S. Curley St.

15 Filed JUL 25 1920 ROBERT B. ...AUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1920

17 I HEREBY CERTIFY, That I attended deceased from July 22nd 1920 to July 23rd 1920

that I last saw her alive on July 22nd 1920

and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 6 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Complete Autopsy

(Signed) H. L. Schwatka M. D.

19 (Address) 27 E. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	July 26 1920
20 UNDERTAKER	ADDRESS
Lilly & Feiler	403 Lex. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

45081

HEALTH DEPARTMENT—CITY OF BALTIMORE

45081

CERTIFICATE OF DEATH.

151

REGISTERED NO.

t-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3817 Foster Ave. ST.: N WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Catherine Helmling.

(a) RESIDENCE. NO. 3817 Foster Ave. ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6yrs yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City. Md.

PARENTS

10 NAME OF FATHER Milton C. Helmling.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Catherine M. Schaaf.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Milton C. Helmling.
(Address) 3817 Foster Ave.

15 Filed JUL 25 1920 ROBERT [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1920

17 I HEREBY CERTIFY, That I attended deceased from 7/22/20, 19..., to 7/23, 1920, that I last saw h[illegible] alive on 7/23, 1920, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Seven months (premature) infant,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) J. H. Randall M. D.

19 (Address) 633-S-3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	July 24 1920
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec. 4-4-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

45082 ✓ 104450 82

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3506 Myrtle Place ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Herold

(a) RESIDENCE. No. 3506 Myrtle Place ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Herold.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Clara Eigner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant George Herold. (Address) 3506 Myrtle Place

15 Filed JUL 25 1920 ROBERT E. TITUS Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1920

17 I HEREBY CERTIFY, That I attended deceased from July 23 1920. that I last saw him alive on July 23 1920. and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro Cretes

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) J. M. Schleuer M. D.

7/24 1920 (Address) 330 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL July 26 19 20

20 UNDERTAKER Lilly and Julius ADDRESS 403 S. Woo

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45083

HEALTH DEPARTMENT—CITY OF BALTIMORE

42 D45083

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Josiah Parker ST.: 23 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 208 W Hamburg St

(a) RESIDENCE. No. 208 W Hamburg ST. 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Commodore

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS (than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Albert Parker (son) (Address) 208 W. Hamburg St.

15 Filed JUL 25 1920 ROBERT E. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1920

17 I HEREBY CERTIFY, That I attended deceased from July 20th 1920 to July 24th 1920, that I last saw h alive on July 24th 1920, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus Unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Bunbury, M. D.

7/24/1920 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parker Creek, Calvert Co. Md.	July 25 1920

20 UNDERTAKER	ADDRESS
John H. Tradin	1421 W Fred

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045084 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045084

CERTIFICATE OF DEATH. 6 104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 N. Durham ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank H. Becker

(a) RESIDENCE. NO. 12 N. Durham ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 28/20

7 AGE: Years | Months: 1 | Days: 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John M. Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Elizabeth Rummel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs. John M. Becker (Address) 12 N. Durham

15 Filed JUL 25 1920 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/24/20

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1920, to July 24, 1920, that I last saw him alive on July 23, 1920, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Enteri- Colitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of — —

Was there an autopsy? — —

What test confirmed diagnosis? — —

(Signed) J. H. Blades, M. D.

(Address) 1436 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: First Evangelical Cem. DATE OF BURIAL: July 26 1920

20 UNDERTAKER: Jos J. Kerr ADDRESS: 156 N. Luzerne ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT NATURE OF DISEASE is very important. See instructions on back of certificates.

D45085 — HEALTH DEPARTMENT---CITY OF BALTIMORE — D45085

CERTIFICATE OF DEATH

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3129 St.: Baker WARD) 15

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Teresa Burns (If St.; yrs. 6 mos. 12 ds.)

(Residence in Baltimore: No. 3129 Baker St.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: June (Month) 11 (Day), 1920 (Year)

7-AGE: — yrs. 6 mos. 12 ds. If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: Norman Thomas Burns

11-BIRTHPLACE OF FATHER (State or country): Balto Md

12-MAIDEN NAME OF MOTHER: Eva Teresa Bitner

13-BIRTHPLACE OF MOTHER (State or country): Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Norman Burns

(Address) 3129 Baker st.

Filed JUL 25 1920 191 ROBERT E. LAMBERT Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: July (Month) 23 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22, 1920, to July 23 1920, that I saw h.r alive on July 23 1920, and that death occurred, on the date stated above, at 7.35 P m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) — yrs — mos. 1 ds.

Contributory (SECONDARY) (Duration) yrs mos ds.

(Signed) Jere Talbott M. D.

July 23 1920 [Address] 1353 E North Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park Cy

DATE OF BURIAL: July 26 1920

20-UNDERTAKER: Harry W. Ebling

ADDRESS 1944 W. North Ave

N. B.—Every item must be answered in plain terms, so that it may be properly classified. Each state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D45086 HEALTH DEPARTMENT—CITY OF BALTIMORE D45086

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 W. Fairmount Ave ST.; 20 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Wuntz

(Residence in Baltimore: No. 1906 W. Fairmount Ave St.; 50 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Widower

6-DATE OF BIRTH, Oct. (Month) — (Day) 1854 (Year)

7-AGE, 65 yrs. 9 mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Invalid 000
(b) General nature of industry, business, or establishment in which employed (or employer): for over 8 Yrs.

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman J. Wuntz

(Address) 1906 Fairmount Aves.

15- Filed JUL 25 1920, 191.... ROBERT B KRAUTER VITAL STATISTICS CLERK

CAUSE OF DEATH in plain terms, so that any one may understand it. Name disease causing death, or if from violence, state the nature of violence, whether accidental, suicidal or homicidal. Do not use indefinite or unmeaning terms, such as "Pneumonia," "Exhaustion," "Heart Failure," "Blood Poisoning," "Septicemia," "Uremia," "Cancer," "Tumor," "Abscess," "Debility," "Old Age," "Infirmities of Age," "Natural Causes," "Malignant Disease," "Tuberculosis," "Consumption," "Convulsions," "Paralysis," "Dropsy," "Fever," "Meningitis," "Hemorrhage," "Asthma," "Jaundice," "Childbirth," "Malpractice," "Murder," "Found Dead," "Killed," "Run Over," "Drowned," "Burned," "Scalded," "Suffocated," "Poisoned," "Shot," "Stabbed," "Fractured Skull," "Concussion of Brain," "Internal Injuries," "Injuries," "Shock," "Homicide," "Suicide," "Accident," "Unknown," "Unascertained," "Not Known," "Not Stated," "Not Given," "Not Certified," "Not Diagnosed," "Not Known if Accidental, Suicidal or Homicidal," "Not Known if Suicidal or Homicidal," "Not Known if Accidental or Homicidal," "Not Known if Accidental or Suicidal

Spec.—6-9-19—H. P. Co.—1000 Bks.

L945087 HEALTH DEPARTMENT—CITY OF BALTIMORE √L945087

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hosp. REGISTERED NO. 37

CITY OF BALTIMORE: (No. ..... ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora Bowen

(a) RESIDENCE. NO. 1332 Myrtle Ave. ST., WARD.
(Usual place of abode) 20 Rubenstown
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Bowen

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
29				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) none 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Missouri Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant (Address) Bay View Hospital Balto, Md

15 JUL 25 1920 ROBERT I KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1920, to July 22, 1920, that I last saw h[illegible] alive on July 22, 1920, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Lues

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Toxic Delirium

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Serological.

(Signed) N. F. Edgerton M. D.

7/23/1920 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	July 25 1920
20 UNDERTAKER	ADDRESS 518
Frank Bowsley	[illegible]

Spec.—8-24-14—M. & T.—2000 Blks.

Valentine J. Miller

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045088 1045088

CERTIFICATE OF DEATH. Violet Hill 113

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 Pinehurst Ave ST.; Apt 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Valentine J Miller

(Residence in Baltimore: No. 19 Pinehurst Ave St.; 35 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Wht	Married

6-DATE OF BIRTH, Dec (Month) 26 (Day), 1884 (Year)

7-AGE, 72 yrs. 6 mos. 27 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stove Mfr
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Joseph Miller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Keene

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry W Taylor

(Address) 19 Pine Heights Ave

15- Filed JUL 25 1920, 191... ROBERT E KRAUTER Registrar. Burial Permit Given

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 18 1920, to July 23 1920, that I saw h- alive on July 22 1920, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

1. Cirrhosis of Liver

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) yrs. mos. ds.

(Signed) Howard W Jones M. D.

July 24 1920 (Address) Dundalk

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, July 26th, 1920

20-UNDERTAKER Joseph B Cook — ADDRESS 1003 W Baltimore St

D45089 HEALTH DEPARTMENT—CITY OF BALTIMORE D45089

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C 5—120

CITY OF BALTIMORE (No. 406 n Eden St.; Ward 5) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Stanley

(Residence in Baltimore: No. 406 n Eden St.; Yrs. 9/12 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: Colo | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Wid

6-DATE OF BIRTH, ..., 1 (Month) (Day) (Year)

7-AGE, 45 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer): work

9-BIRTHPLACE, (State or Country), Born in Baltimore City

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Husband James Stanley

(Address) 406 Eden St

15- JUL 25 1920 Filed ....., 191.... ROBERT E KRAUTER Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 22, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Max Stanley M. D. (Coroner)

7-22, 1920 (Address) 9 E Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Edgewood Cem. DATE OF BURIAL, July 25, 1920

20-UNDERTAKER Mrs R A Elliott ADDRESS 1725 Lakewood Ave

N.B.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

142150 2145090

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045090

CERTIFICATE OF DEATH.

14

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. George Queen

(a) RESIDENCE. No. 544 Mosher ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): Dec. 3, 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: George Queen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Grace Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Hospital Record

(Address) ROBERT B. BRANTLY

15 Filed JUL 25 1920 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 24 1920

17

I HEREBY CERTIFY, That I attended deceased from July 17, 1920, to July 24, 1920, that I last saw h.. alive on July 24, 1920, and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary): none

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? P.T.S. home

Did an operation precede death? no Date of. —

Was there an autopsy?

What test confirmed diagnosis? Stool culture

(Signed) ..... M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 26th 1920
20 UNDERTAKER	ADDRESS
Sam. W. Chase—son	1400. Mosher st

CAUSE OF DEATH must be given in plain terms, and the certificate must be signed and dated as directed on back of certificate. TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D45091

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 763 Saratoga St.; 4 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeremiah Stafford Sr.

(Residence in Baltimore: No. 763 Saratoga St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col	Married

6-DATE OF BIRTH, November 12, 1869 (Month) (Day) (Year)

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) 015

9-BIRTHPLACE, (State or Country), Cambridge Md

PARENTS.

10-NAME OF FATHER, David Stafford

11-BIRTHPLACE OF FATHER (State or Country), Cambridge Md

12-MAIDEN NAME OF MOTHER Sofa Marine

13-BIRTHPLACE OF MOTHER (State or Country), Cambridge

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hester Stafford

(Address) 763 W. Saratoga st.

15- Filed JUL 25 1920, 191.. ROBERT B. CRAUTER REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 22, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 3 1920, to July 22 1920, that I saw him alive on July 21 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cardio vascular Disease

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. S. McCard M. D.

7/24 1920 (Address) 2005 E. Hillen

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Ft Auburn	July 25 1920
20-UNDERTAKER	ADDRESS
Chas. H. Grace & Son	1420 Madison

CAUSE OF DEATH in plain terms, so that it may be understood. All items important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45092

104 D45092

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 326 N Bruce St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Gray

(Residence in Baltimore: No. 326 N Bruce St.; ..... yrs., 1 mos. 23 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Fem	Col	

6-DATE OF BIRTH, June (Month) 1 (Day), 1920 (Year)

7-AGE, ...yrs. 1 mos. 23 da. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Albert Hawkins

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Mary Gray

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Gray

(Address) 720 Hanover

15- JUL 25 1920 ROBERT B KRAUTER

Filed ..... 191... Registrar

Burial Permit

CAUSE OF DEATH in plain words. Every answer important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 24 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 20 1917, to July 24 1920, that I saw h[illegible] alive on July 1920, and that death occurred, on the date stated above, at 6a. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(Duration) ....yrs. ....mos. 14 da.

CONTRIBUTORY (Secondary) Dysentery

(Duration) ....yrs. ....mos. 14 da.

(Signed) [illegible] M. D.

July 24 1920 (Address) 713 S. Chas. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, July 25, 1920

20-UNDERTAKER Jas F. Chase & Son

ADDRESS 1101 Madison

Spec.—8-24-14—M. & T.—2000 Bks.

1045093. HEALTH DEPARTMENT—CITY OF BALTIMORE 1045093.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1438 Ward St.; 21 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rufus Hall

(Residence in Baltimore: No. 1438 Ward St.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	C	Wid

6-DATE OF BIRTH, July (Month) 20 (Day), 1857 (Year)

7-AGE, 63 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Amherst C Md

PARENTS.

10-NAME OF FATHER, James Hall

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Annie Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Hall

(Address) 1438 Ward St

15-JUL 25 1920 Filed, 191 ROBERT E KRAUTER Registrar.

Burial Permit Issued

CAUSE OF DEATH to be filled in by Physician only. It important See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 22 191, to July 23 1920, that I saw h alive on July 23 191, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Organic Diseases of Heart

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 1 ds.

(Signed) J J Moore M. D.

July 23, 191 (Address) 939 N Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	July 26, 1920
20-UNDERTAKER	ADDRESS
Thompson Tarland	114 N. Schroeder St

Spec.—8-24-14—M. & T.—2000 Blks.

1045094 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045094

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO. C

CITY OF BALTIMORE: (No. Memorial ST.; 13 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Blum

(Residence in Baltimore: No. Granada Apart. St.; 38 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day) 1 (Year)

7-AGE, 57 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Shoe Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) 045

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Blum

(Address) Granada Apts

15- ROBERT I KRAUTER

Filed ....., 191.... (Clerk) Registrar.

JUL 25 1920

CAUSE OF DEATH in plain terms. Every item important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 24 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 9 1920, to July 24 1920, that I saw him alive on July 24 1920, and that death occurred, on the date stated above, at 7:45a m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

..... (Duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary)

Broncho pneumonia (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Sidney D. Lee M. D.

7-24 ....., 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Washington Blvd. DATE OF BURIAL, July 25 1920

20-UNDERTAKER S. Levinson & Bro ADDRESS 1129 E Balto St.

Spec.—8-24-14—M. & T.—2000 Blks.

D45096 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D45095

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 Ceral ST.; Curtis Bay 104 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Zylko

(Residence in Baltimore: No. 11 Ceredi St ST.; yrs., 1 mon. 22 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June 2, 1920 (Month) (Day) (Year)

7-AGE, yrs. 1 mos. 22 da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Curtis Bay Md

PARENTS.

10-NAME OF FATHER, Antoni Zylko

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Mary Szymanski

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antoni Zylko

(Address) 11 Ceredi St

15- Filed JUL 25 1920 ROBERT E KRAUTER Registrar

Burial Permit

CAUSE OF DEATH must be plainly written. Every question must be answered if important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 24, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 23 1920, to 191, that I saw her alive on July 23 1920, and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Insanity

(Duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Gastro enteritis

(Duration) yrs. mos. 10 da.

(Signed) Leon D. Stanka M. D.

July 24, 1920 (Address) Curtis Bay Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross | DATE OF BURIAL, 7/25, 1920

20-UNDERTAKER Wm Fallkowski | ADDRESS 1618 Eastern

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45096 HEALTH DEPARTMENT—CITY OF BALTIMORE D45096

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 319 S. Stricker ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Potrcuski

(a) RESIDENCE. NO. 319 S. Stricker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): ~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): July 2, 1919

7 AGE: Years: 1 yr | Months: | Days: 22 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Clement Potrcuski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Bertha Drenga

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Clement Potrcuski

(Address) 2213 Eastern Ave

15 Filed JUL 25 1920 19 ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 24 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to July 24, 1920, that I last saw h alive on July 23, 1920, and that death occurred, on the date stated above, at 5.30a m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. 1 hour

CONTRIBUTORY (Secondary) Gastro-Enteritis

(duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) M. A. O'Neill M. D.

7/25, 1920 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus DATE OF BURIAL: July 25 1920

20 UNDERTAKER: John M Weber ADDRESS: 1803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45097 HEALTH DEPARTMENT—CITY OF BALTIMORE D45097

CERTIFICATE OF DEATH. X 28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 543 Columbia Ave ST.. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rozella L Hart

(a) RESIDENCE. No. 543 Columbia ave ST.. WARD. Harrisburg Pa

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. 15 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 25 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20			

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Telephone

(b) General nature of industry, business, or establishment in which employed (or employer) Operator

(c) Name of employer C. D. Telephone Co Harrisburg Pa

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Charles C Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma R Beal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Emma R Hart (Address) 543 Columbia Ave

15 Filed JUL 25 1920 [illegible] F KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8 1920, to July 22nd 1920, that I last saw her alive on July 22nd 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Tubercle bacilli in sputum

(Signed) M Kahn, M. D.

(Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harrisburg Pa	July 26 1920

20 UNDERTAKER Wm Bosh ADDRESS 1526 E north Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Attention is called to the importance of certificates. TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45098

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45098

CERTIFICATE OF DEATH.

130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 Westphal Place ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Mattley

(a) RESIDENCE. NO. 1827 Westphal Place ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of Adelbert Mattley

6 DATE OF BIRTH (month, day, and year) May 15, 1850.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Geo. Donnellan (Address) 1827 Westphal Place

15 Filed JUL 26 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 15. 1919. to July 24. 1920

that I last saw her alive on July 24. 1920.

and that death occurred, on the date stated above, at 9.50 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Chronic Brights Disease

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Brights Disease

(duration) 1 yrs. 5 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. J. Kennard M. D.

7-24-1920 (Address) 708 Enver St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. A.A.C.	July 27 1920
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1432 Light

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec —6-9-19— H. P. Co.—1000 Bks.

D45099

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45099

172

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1286 Battery Ave ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Butler

(a) RESIDENCE. NO. 1286 Battery Ave WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of Wm. T. Butler

6 DATE OF BIRTH (month, day, and year) Mar. 7, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John McElhaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Neil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Mamie Butler (Address) 1286 Battery Ave.

15 JUL 26 1920

G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22nd 1920

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1920, to July 22nd, 1920, that I last saw h.e alive on July 22nd, 1920, and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Senile debility & bronchitis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Shock from a fall

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Emma H. Brune M. D.

July 27 1920 (Address) 1223 S. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL Jan. 26 1920

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Light St

N. B.—WRITE PLAIN... mation should b... CAUSE OF DEA... TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Tripped + fell on floor

Spec.—6-9-19—H. P. Co.—1000 Blks.

45100

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 45100

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 South Bond ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Henry Grimm

(a) RESIDENCE. NO. 825 South Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 17, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	5	17	

8 OCCUPATION OF DECEASED 040

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Northern

(c) Name of employer Central Railroad

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Grimm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresia Kunzel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Theresia Esser
(Address) 625 South Durham St

15 Filed JUL 26 1920 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1920

17 I HEREBY CERTIFY, That I attended deceased from July 16, 19 20, to July 24, 19 20, that I last saw h— alive on July 24, 19 20, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Acute Gastritis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Wenken, M. D.

(Address) 16 E Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	July 27 1920
20 UNDERTAKER	ADDRESS
H. Vander & Son	710 Fleet St.

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

2 45101 — 104 — 45101

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Whitmore St ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard E. Holmes

(a) RESIDENCE. No. 1102 Whitmore St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 1 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) June 30/19

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Samuel Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth Newman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Dr Chas A Fetterhoff Md

(Address) 1807 N. North ave

15 Filed JUL 26 1920 Registrar G. H. Grese.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1920

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1920, to July 25, 1920, that I last saw him alive on July 24, 1920, and that death occurred, on the date stated above, at 5.20 m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? my

(Signed) Chas A Fetterhoff, M. D.

, 19 (Address) 1807 N North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	7/26-20
20 UNDERTAKER	ADDRESS
I. Few McCully	130 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D45102 HEALTH DEPARTMENT—CITY OF BALTIMORE D45102.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH. CITY OF BALTIMORE (No. 820 N Parish alley St.; 16 WARD) REGISTERED No. C 79v

2-FULL NAME. Josephine Brown

(Residence in Baltimore: No. 820 N Parish alley St.; 40 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F. 4-COLOR OR RACE, C- 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. Exact date not known, 1875 (Month) (Day) (Year)

7-AGE, 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Cook. (b) General nature of industry, business, or establishment in which employed (or employer). Private

9-BIRTHPLACE, (State or Country). Howard Co. Maryland.

PARENTS.

10-NAME OF FATHER. Jo. Brown

11-BIRTHPLACE OF FATHER (State or Country). Howard Co. Md

12-MAIDEN NAME OF MOTHER. Victoria Williams

13-BIRTHPLACE OF MOTHER (State or Country). Howard Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ruth Thornton

(Address) 820 N. Parrish

15-

Filed JUL 26 1920 191 G. H. Crese Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7 (Month) 24 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows:

Mitral Stenosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Anasarca

(Duration) yrs. mos. 14 ds.

(Signed) Geo C Blades M. D. (Coroner.)

7/25/20 191... (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DATE OF BURIAL, July 26, 1920

20-UNDERTAKER Wm. H. Case Sons ADDRESS 1400 Madison

N. B.—EVERY BLANK must be filled out, so that it may be properly classified. Exact statement of OCCUPATION is important. CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45103 D 45103

CERTIFICATE OF DEATH.

5-79

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 537 N. Bay ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Kuestel

(Residence in Baltimore: No. 537 N. Bay St.; 58 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, July (Month) 15 (Day) 1850 (Year)

7-AGE, 70 yrs. — mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Theodor Wastl

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Sophia Dorfler

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick F. Kuestel

(Address) 537 N. Bay

15-

Filed JUL 26 1920 G. H. Cress Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 23 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1918, to July 23 1920, that I saw her alive on Jan 23 1920 and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Senile Insufficiency

(Duration) 10 yrs. — mos. — ds.

(Signed) John Boteler M. D.

7/24 1920 (Address) 936 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, July 25, 1920

20-UNDERTAKER Geo. Weber & Son

ADDRESS 2503 Edmondson Ave

CAUSE OF DEATH to be plain terms, so that no doubt may exist as to its meaning. Abbreviations should not be used. Every item should be answered if possible, but if not, "unknown" or the best obtainable information should be given. Be particular to fill in the space for duration of disease, and to state whether primary, secondary, or contributory. Physicians are requested to report cases of death from violence immediately by telephone. Burial permit will not be issued until certificate is filed. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45104

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: NO. 1024 n wolfe ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mosis Allen

(a) RESIDENCE. NO. 1024 n wolfe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) va

PARENTS

10 NAME OF FATHER James Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) va

12 MAIDEN NAME OF MOTHER Annie McNeal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) va

14 Informant Jane Allen
(Address) 1024 Wolf St

15 Filed JUL 26 1920 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1920

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1920, to July 25, 1920.
that I last saw him alive on July 24, 1920,
and that death occurred, un the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Toxemia 3 wks)

3 mo (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Toxemia 3 wks
(duration) yrs. mos. 3 wks

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) H Edward Fisher, M. D.

, 19 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	JUL 27 1920
20 UNDERTAKER	ADDRESS
R C Gross	1405 McElderry

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

845105

HEALTH DEPARTMENT—CITY OF BALTIMORE

845105

CERTIFICATE OF DEATH.

152

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby George Douglas Christie

(a) RESIDENCE. No. 1717 Madison Ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/23/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Christie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Belle McDonnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Geo. D. Christie

(Address) 1717 Madison Ave

15 Filed JUL 26 1920 G. H. Gresse Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/24 1920

17 I HEREBY CERTIFY, That I attended deceased from 7/20, 1920, to 7/24, 1920, that I last saw him alive on 7/24, 1920, and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Arterial Compression

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Weak Forceps Delivery

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emmett D. Ridgely M. D.

(Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	7/26 1920
20 UNDERTAKER	ADDRESS
Henry W. Meaux & Son	805 N. Calvert St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT IS very important. See instructions on back of certificates.

D45106

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 D45106

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1813 East 28th St. WARD) 9

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Louis P. Dickerson

(Residence in Baltimore: No. 1813 East 28th St. St.: 61 yrs. 9 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Oct 11th (Month) (Day), 1858 (Year)

7 AGE: 61 yrs. 9 mos. 22 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): 2nd Nat. Bank

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Geo. Dickerson

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie R. Dickerson

(Address) 1813 E 28th St

15 Filed JUL 26 1920 G. H. Grese REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 23 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1919, to July 21 1920, that I saw him alive on July 21, 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(Duration) 1 yrs. 4 mos. ..... ds

Contributory (SECONDARY) Asthenia

(Duration) ..... yrs. 4 mos. 1 ds.

(Signed) Flora McCarty M. D.

July 23, 1920 (Address) 1112 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Pk — DATE OF BURIAL: July 26, 1920

20 UNDERTAKER: Philip Henry — ADDRESS: 2016 Orleans St

N. B.—Every item of information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. For infants, state AGE in HOURS or MINUTES. Even statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 45107

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45107

CERTIFICATE OF DEATH.

137

1-PLACE OF DEATH

REGISTERED NO. C 20

CITY OF BALTIMORE: (No. 2565 W Fairmount Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beatrice Irene Artman

(Residence in Baltimore: No. Balto & Garrison Lane ST.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, July (Month) 1 (Day), 1896 (Year)

7-AGE, 24 yrs. mos. 24 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....W. 137
(b) General nature of industry, business, or establishment in which employed (or employer)....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER Samuel W. Curville

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Frances V. Lunick

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel W. Curville

(Address) 2565 W Fairmount Ave

15-

Filed JUL 26 1920 191....

G. H. Cresse. Registrar.

CAUSE OF DEATH to be plain terms, so that any one may understand it. Technical terms are not important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7 (Month) 24 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 7-4 1920, to 7-24 1920, that I saw her alive on 7-24 1920, and that death occurred, on the date stated above, at 12 a.m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

Labor Instigation (Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Puerperal Peritonitis (Duration) ....yrs. ....mos. 7 ds.

(Signed) A. P. Chelin M. D.

7/24/20 191.. (Address) 2757 W North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, July 26-20

20-UNDERTAKER F. B. Kappel — ADDRESS 1336 Frederick Ave

over

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45108

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45108

CERTIFICATE OF DEATH.

42

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2529 W. Pratt ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Riggen

(a) RESIDENCE. NO. 2529 W. Pratt ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Riegger

6 DATE OF BIRTH (month, day, and year) Feb 9, 1864

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	54	5	15	X

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work House wife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Sunny Brook (State or country) Maryland.

PARENTS

10 NAME OF FATHER Christian Rugger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Filucke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anthony Riegger (Address) 2529 W Pratt St

15 Filed OCT 25 1920 19

Registrar G. H. Gross.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 19 20

17 I HEREBY CERTIFY, That I attended deceased from July, 1919, to July 24, 1920, that I last saw h— alive on July 23rd, 1920, and that death occurred, on the date stated above, at 7. A. m.

The CAUSE OF DEATH* was as follows:

Cancer of uterus, bladder and rectum

(duration) 1 yrs. X mos. X ds.

CONTRIBUTORY (Secondary) Cancer - septic infection (duration) X yrs. 3 mos. X ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? NO Date of X

Was there an autopsy? NO

What test confirmed diagnosis? examination

(Signed) P. Wilson, M. D.

7/24. 1924 (Address) 1124 W. Lafayette Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	July 27 1920
20 UNDERTAKER	ADDRESS
F. D. Keppert	2236 Frederick Ave

TION is very important. See instructions on back of certificate.

D45709 HEALTH DEPARTMENT—CITY OF BALTIMORE D45709

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Foot of 7th. St. Masonville St.: 25 WARD) 169 REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milton W. Pitts.

(Residence in Baltimore: No. 12 N. 4th. St. Brooklyn. St.; 14 yrs., ---- mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, July 4th. 1906., / (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
14 yrs. ---- mos. 19 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None. 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Brooklyn Md.

PARENTS.

10-NAME OF FATHER, Robert L. Pitts.

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER Elizabeth G. Collison

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert L. Pitts. (father)

(Address) 12 N. 4th. St. Brooklyn.

15-

Filed JUL 26 1920, 191.... G. H. Grese. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 23rd. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Drowned while in swimming

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

July 24, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	July 27 1920
20-UNDERTAKER JOHN F. DENNY	ADDRESS 715 LIGHT ST.

N. B.—Every item of information should be given if possible. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be understood, is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1500 Bks.

D 45160

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45110

CERTIFICATE OF DEATH.

REGISTERED NO. 14

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.: 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Gertrude Courtney

(a) RESIDENCE. No. 1649 Abbott St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 17, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cndy. Packer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Edward Courtney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth Tillman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Mrs Elizabeth Courtney

(Address) 1649 Abbott St

15 Filed July 24 1920 G. H. Gr... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/25 1920

17 I HEREBY CERTIFY, That I attended deceased from 7/22, 1920, to 7/25, 1920, that I last saw h[illegible] alive on 7/25, 1920, and that death occurred, on the date stated above, at 4 A. m. The CAUSE OF DEATH* was as follows:

Suspected Septic Arm following a Furuncle She opened with a needle

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/22; 7/24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emma A. Rodgers, M. D.

7/25, 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 27, 1920

20 UNDERTAKER E. D. Fanning & Son ADDRESS 1938 Lafayette Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Name of disease alone is not sufficient. Do not use abbreviations or initials. Do not report symptoms. If deaths from violence, state whether Accidental, Suicidal, or Homicidal. Fill in all blanks. Write plainly. Use black ink. Do not write across face of certificates. TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45111

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D45111

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospitals, Bay View WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Schriver, Jr.

(a) RESIDENCE. NO. 3045 Huntington Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 12, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Richard Schriver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Lizzie Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md

14 Informant Hospital Records. (Address)

15 Filed AUG 26 1920 19 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1920.

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1920, to July 24, 1920, that I last saw h[illegible] alive on July 24, 1920, and that death occurred, on the date stated above, at 2 30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of pancreas.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of? At another hospital

Was there an autopsy? Not

What test confirmed diagnosis? —

(Signed) V B Newman, M. D.

7-28 1920 Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents Cemetery	7/27 1920
20 UNDERTAKER	ADDRESS
E. J. Fanning & Son	1938 E Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificates.

D 45112 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45112

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C 169

City of Baltimore (No. 2205 Druid Hill Ave. St.; 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lawrence Kinnard

(Residence in Baltimore: No. 730 S Howard St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Negro	Single

6-DATE OF BIRTH, Aug 10, 1911
(Month) (Day) (Year)

7-AGE, 8 yrs. 11 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Edward Kinnard

11-BIRTHPLACE OF FATHER (State or Country), Calvert County Md

12-MAIDEN NAME OF MOTHER, Hattie Hunt

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Kinnard

(Address) 730 S Howard St

15-

Filed JUL 26 1920, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 24, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Henry Von Mosley M. D. (Coroner.)

July 24, 1920 (Address) 16 E. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cemetery	7-26-, 1920
20-UNDERTAKER John H. Toadvine	ADDRESS 142 W. Hill St

N.B.—Every item of information should be given, so that it may be properly classified. Paper statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45113 — 502 D 45113

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital, 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Gibson Miller

(a) RESIDENCE. NO. 1718 E Lafayette ST., 8th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May 20, 1895

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
25	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Roofing products

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Robert L. Miller

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rosanna Irving

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant James L. Miller
(Address) 1744 E Lafayette

15 Filed JUL 29 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1920

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1920, to July 26, 1920, that I last saw him alive on July 25, 1920, and that death occurred, on the date stated above, at 2.00 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ....yrs. ....mos. 4 days.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of /

Was there an autopsy? no

What test confirmed diagnosis? Analysis urine

(Signed) Thos. L. Galvani M. D.

, 19 (Address) 1820 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 29 1920
20 UNDERTAKER	ADDRESS
John B. Spence	1325 N. Caroline St

CAUSE OF DEATH in plain terms, as per rules on back of certificates. See instructions on back. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT--CITY OF BALTIMORE.

D 45114 — 64 — D 45114

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2008 Fairmount ave 6 ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Fiskery

(Residence in Baltimore: No. 2068 Fairmont Ave St.; ..... yrs., ... mos. ..... dls.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH. June 11th (Month) (Day), 1830 (Year)

7-AGE. 90 yrs. 1 mos. 13 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): N.O.

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Joseph Fragery

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Gilmore

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Hoaner

(Address) 916 W. Washington St

15-

Filed ..... 191.... G. H. Grese Registrar.

JUL 29 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 11 1920, to July 22 1920, that I saw her alive on " " 1920, and that death occurred, on the date stated above, at 7-10 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis Brain

Hemiplegia

(Duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary) Hemorrhage Brain

(Duration) ... yrs. ... mos. 11 ds.

(Signed) J. H. Goldberg M. D.

July 25, 1920 (Address) 1810 Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cem

DATE OF BURIAL. July 26 1920

20-UNDERTAKER Wm. T. Hartley

ADDRESS 814 W. Washington St

Order of questions should be followed closely as important. See instructions on back of certificate.

D45115 HEALTH DEPARTMENT—CITY OF BALTIMORE D45115

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 1337 Whatcoat St.: 15 WARD) REGISTERED NO. C 184

2-FULL NAME Melia Hopkins

(Residence in Baltimore: No. 1337 Whatcoat St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F. 4-COLOR OR RACE, C- 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, ... 1856 (Month) (Day) 1 (Year)

7-AGE, 34 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Cook
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.
10-NAME OF FATHER, George Hopkins
11-BIRTHPLACE OF FATHER (State or Country). Maryland
12-MAIDEN NAME OF MOTHER Emma Johnson
13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Reese Gresh
(Address) 1337 N Whatcoat

15- JUL 26 1920 Filed ....., 191.... G. H. Grese. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7 23, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Self Induced Abortion
(Duration) 5 yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Peritonitis
(Duration) yrs. mos. ds.
(Signed) G. C. Cole M. D.
(Coroner.)
7/24/20 (Address) 1437 E Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, July 26 1920

20-UNDERTAKER JAMES H. DENNIS — ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is important. See instructions on back of certificate.

D 45116

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45116

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 5175 Eastern Ave St.) WARD)

REGISTERED No. C 201

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gilbert Goldberg

(Residence in Baltimore: No. 1016 E Fayette St) St.: 7 yrs., 11 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sgle

6-DATE OF BIRTH, Aug 21, 1917
(Month) (Day) (Year)

7-AGE, 7 yrs. 11 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) School

9-BIRTHPLACE, (State or Country), Balto city Md

PARENTS.

10-NAME OF FATHER, William Goldberg

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Annie Johnisky

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Levis

(Address) 1411 E Balt St

15-

Filed JUL 26 1920, 191.... C. H. Cross
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) held July 26-1920, find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

I. Fract of skull and other injuries. Struck by automobile

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) M. M. Daly (Coroner.) M. D.

July 26, 1920 (Address) 16 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Workmen circle

DATE OF BURIAL, July 26 1920

20-UNDERTAKER Mt Carmel

ADDRESS 1411 E Balt

Jack Levis

CAUSE OF DEATH in plain terms, so that it may be properly classified. Omit abbreviations. Each statement is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45117

CERTIFICATE OF DEATH.

D45117

REGISTERED NO. 1179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1625 E. Monument ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Chester

(a) RESIDENCE. NO. 1625 E. Monument ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored.	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Constance Chester.

6 DATE OF BIRTH (month, day, and year) April 14 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
48		3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter. 070

(b) General nature of industry, business, or establishment in which employed (or employer) Optician.

(c) Name of employer Wm. B Brown.

9 BIRTHPLACE (city or town) (State or country) Dorchester. County. Md

PARENTS

10 NAME OF FATHER Wm. Chester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester County. Md.

12 MAIDEN NAME OF MOTHER Annie Dockins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester County Md.

14 Informant Wm. Wesley Chester Bal. MD

(Address) 1428 E Monument St.

15 Filed JUL 26 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1920, to July 25, 1920, that I last saw h[illegible] alive on July 24, 1920, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas C Robinson M. D.

1920 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL

Laurel Cemetery July 28 1920

20 UNDERTAKER ADDRESS

Chas G Bailey 147 Eastern Ave

R. R.—WRITE PLAINLY, with ink or indelible pencil. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

D 45118 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45118

159

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George F. Lambert

(Residence in Baltimore: No. 118 S Monroe St St. (yrs., 26 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Mal	white	Married

6-DATE OF BIRTH, May (Month) 14 (Day), 1862 (Year)

7-AGE, 58 yrs. 2 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer)..... Odd

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John F. Lambert

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Lambert

(Address) 118 S. Monroe St

15-

Filed JUL 26 1920 191 G. H. Gres Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 24 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound

Brain Dec. Instantaneous

Suicide

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Hemorrhage

Brain (Duration) ....yrs. ....mos. 1 ds.

(Signed) James W. Gordon M. D. (Coroner.)

July 25 1920 (Address) Town Clerk

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 118 S Monroe St

19-PLACE OF BURIAL, OR REMOVAL, Loudon Park

DATE OF BURIAL, July 26 1920

20-UNDERTAKER Harry H. Witzke

ADDRESS 1531 W. Lombard St

N.B.—Every item of information should be carefully supplied, that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 45119

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 D 45119

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 S. Stricker ST.; 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Baker

(a) RESIDENCE. No. 229 S. Stricker ST., WARD. 19

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 25 yrs. 6 mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Baker

6 DATE OF BIRTH (month, day, and year) March 11, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
61	60	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Frank Ebrle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Elz. Kool

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Rudolph Printz

(Address) 229 S. Stricker St

15 Filed JUL 28 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1920.

17 I HEREBY CERTIFY, That I attended deceased from July 14. 1920 to July 25th. 1920. that I last saw h.r alive on July 24th. 1920. and that death occurred, on the date stated above, at 1 am m.

The CAUSE OF DEATH* was as follows:

Method Regurgitation

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Asthma & Dropsy

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Ben Duncan M. D.

7/30 19 (Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	July 27 1920
20 UNDERTAKER A. Jones	ADDRESS 2078 Stricker st

CAUSE OF DEATH is plain terms, so that a ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45120 HEALTH DEPARTMENT—CITY OF BALTIMORE D45120

CERTIFICATE OF DEATH

1-PLACE OF DEATH 410 Asquith St 5-28 REGISTERED NO.....

CITY OF BALTIMORE: (No.) ... ST.: ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Stevenson

(a) RESIDENCE. NO. 410 Asquith St.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 6 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: (Single)

6 DATE OF BIRTH (month, day, and year): Jan 1, 1887

7 AGE — Years: 33 — Months: 6 — Days: 23 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Moses Stevenson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Boonsboro Md.

12 MAIDEN NAME OF MOTHER: Laura Bullard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sommerset Co Md

14 Informant ..... (Address): Laura Stevenson 410 Asquith

15 Filed JUL 28 1920 G. H. Gosse Registrar

CAUSE OF DEATH in plain terms, so that it may be classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1920

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1920 to July 23, 1920. that I last saw him alive on July 23, 1920 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phisis

(duration) — yrs. one mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. C. Lantz, M. D.

(Address) 1324 N. Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: July 24 1920

20 UNDERTAKER: Wm R A Elliott — ADDRESS: 1725 Ashland Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

045121 ✓ 28 045121

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Municipal Tuberculosis Hospital St.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara M. Harvey

(a) RESIDENCE. NO. 18 S. Spring St. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework 070
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS
10 NAME OF FATHER James H. Harvey
11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland
12 MAIDEN NAME OF MOTHER Catherine Boston
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed JUL 28 1920 G. H. Creer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1920

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1920, to July 24, 1920, that I last saw her alive on July 24, 1920, and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
(duration) 1 yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Tuberculous entero-colitis
(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? T.B. in sputum, X-ray
(Signed) L. J. Cayley, M. D.
7-25-20, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	July 28 1920
20 UNDERTAKER	ADDRESS
Bvrs R A Elliott	Oakland Ave

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

D 45122

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45122

CERTIFICATE OF DEATH.

1042

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 827 Leadenhall St. ST.: 22 WARD) REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Freeman. (C)

(Residence in Baltimore: No. 827 Leadenhall St. St.; ~~yrs.~~, 5 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored	Single.

6-DATE OF BIRTH, February 22nd. 1920., 1
(Month) (Day) (Year)

7-AGE, ~~yrs.~~ 5 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Thomas Jones. (C)

11-BIRTHPLACE OF FATHER (State or Country), Jamaica.

12-~~MAIDEN~~ NAME OF MOTHER Hattie Freeman. (C)

13-BIRTHPLACE OF MOTHER (State or Country), South Carolina.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Freeman. (C) mother.

(Address) 827 Leadenhall St.

15-

FILED JUL 26 1920 191.....

Registrar.

G. H. Grese.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 25th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....Diarrhoea.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....Exhaustion.....

..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

July 25th. 191. 20 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn et — DATE OF BURIAL, July 27 1920

20-UNDERTAKER, L. H. Bromwell Son — ADDRESS 708 W. Monument

N. B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information of occupation may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

045123

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 045123

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 18 WARD)

2-FULL NAME William Harris

(a) RESIDENCE. No. 1004 Lexington St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20			

8 OCCUPATION OF DECEASED 121

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles Harris

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania

14 Informant Hospital Records
(Address) M.T.H.

15 Filed JUL 26 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to July 20, 1920, that I last saw h im alive on July 20, 1920, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed) W. L. Rigney, M. D.

7-21-20, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	JUL 24 1920 19
20 UNDERTAKER	ADDRESS
Commissioner Health,	

Per. Wm. E. Woodall

CAUSE OF DEATH should be plainly written, and items on back of certificate. TION is very important. See instructions on back of

6

1535

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45124 D45124

CERTIFICATE OF DEATH.

151

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 537 Wilson ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Avon Brooks

(Residence in Baltimore: No. 537 Wilson St. St.; ...yrs., 1 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 19, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Avon Brooks

11-BIRTHPLACE OF FATHER (State or Country), A.A. County

12-MAIDEN NAME OF MOTHER Evelyn Monroe

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Avon Brooks

(Address) 537 Wilson St

15-

JUL 26 1920 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 24, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 12 1920, to July 24 19[redacted], that I saw h[redacted] alive on July 24 19[redacted], and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH was as follows:

.....

Prematurity

..... (Duration) ...yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Intoxication, Intestinal

..... (Duration) ...yrs. ...mos. 3 ds.

(Signed) C. L. Joslin M. D.

July 24, 1920 (Address) 333 W. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, 7/26, 191...

20-UNDERTAKER Mrs. Geo. Hooper — ADDRESS 406 N. Carey St

important. See instructions on back of certificate.

D45125

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D/45125

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 East 25th ST.: 12 WARD)

2-FULL NAME Minnie P. Beale

(a) RESIDENCE. NO. 104 East 25th ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 16. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 800

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Rev. John S. Beale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah B. Buchanan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant John S. Beale

(Address) 2752 Maryland Ave

15 Filed JUL 26 1920 19 ROBERT P. PRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1920

17 I HEREBY CERTIFY, That I attended deceased from June, 1913, to July 25, 1920, that I last saw her alive on July 24, 1920, and that death occurred, on the date stated above, at 5:10 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis and Arterio-sclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy -

(duration) yrs. 1 mos. 10 hrs

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Robert Armistead, M. D.

July 26 1920 (Address) 2112 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	July 27 1920
20 UNDERTAKER John C. Mitchell	ADDRESS 1201 W Fayette

CAUSE OF DEATH in plain terms, so that it may be intelligible on back of certificates. TION is very important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Blks.

D 45126

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45126

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 Emory St. ST.; 21 WARD) REGISTERED No. C 104

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Glenn Elbin Morgan

(Residence in Baltimore: No. 216 Emory St. St., life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, ... yrs. 19 mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, George Morgan

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Ethel Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. Morgan

(Address) 216 Emory St

15- Filed JUL 26 1920, 191... ROBERT P. LAMUTH Registrar.

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 26 (Month) (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1920, to July 25 1920, that I saw him alive on July 24 1920, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Enteric - Colitis

(Duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. D. Smith M. D.

July 26, 1920 (Address) 132 W. Lee St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Fairmount Place — DATE OF BURIAL, July 27, 1920

20-UNDERTAKER R. L. Parham — ADDRESS 131 N. Paca

Should be filled out in all cases. Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

W45127

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

L45127

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Gordon

(Residence in Baltimore: No. ..... St.; .....yrs., ...mos. .....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	Black	Single

6-DATE OF BIRTH. October (Month) 7 (Day), 1898 (Year)

7-AGE. 21 yrs. 9 mos. 10 da. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Domestic A.P.
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Housework

9-BIRTHPLACE, (State or Country), Richmond. Va.

PARENTS.

10-NAME OF FATHER, John Fitzhugh

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Mahaila Fitzhugh

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Patrick J. Brady

(Address) Md. Pen.

15- JUL 26 1920 191.... ROBERT E KRAUTER Registrar

Burial Permit Issued

Morgue

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH July (Month) 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 9 1920, to July 17 1920, that I saw her alive on July 16 1920, and that death occurred, on the date stated above, at 2.45 p. m.

The CAUSE OF DEATH* was as follows:

Inanition - Exhaustion

Cardiac failure

(Duration) ..... yrs. ..... mos. 14 da.

CONTRIBUTORY (Secondary) Tuberculosis Peritonitis

(Duration) ..... yrs. 3 mos. 8 da.

(Signed) William F. Edwards M. D.

July 17..., 1920 (Address) Md. Penitentiary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 yrs. 1 mos. 1 da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence Washington D.C.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS JUL 26 1920

Commissioner Health.

UNIVERSITY OF MARYLAND

WOODALL

Record of Deaths. See instructions on back of certificate. important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1945128

HEALTH DEPARTMENT—CITY OF BALTIMORE

1945128

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Gaskins

(a) RESIDENCE. No. 1800 Dallis ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown 057

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) ROBERT E. LEMMER

15 Filed JUL 26 1920 Burial Permit Clerk Registrar

17358

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1920

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1920, to July 23, 1920, that I last saw him alive July 23, 1920, and that death occurred, on the date stated above, at 12:10 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interst. Nephritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bronustas M. D.

7-23-20, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL JUL 26 1920

20 UNDERTAKER Commissioner Health.

ADDRESS

CAUSE OF DEATH must be stated plainly. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

1045129

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045129

CERTIFICATE OF DEATH.

151

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 Erdman Ave ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Michael Burns Jr.

(Residence in Baltimore: No. 2108 Erdman Ave — St.; ... yrs., 1/2 hr mos. ... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED~~ (Write the word.) Single

6-DATE OF BIRTH. July 26th, 1920. (Month) (Day) (Year)

7-AGE. 1/2 hr. ... yrs. ... mos. ... da.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), ~~2108~~ Maryland.

PARENTS:

10-NAME OF FATHER, John M. Burns

11-BIRTHPLACE OF FATHER (State or Country), Nashville Tenn

12-MAIDEN NAME OF MOTHER Mary Creaghan

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John M. Burns

(Address) 2108 Erdman Ave

15- JUL 26 1920 Filed ..., 19... ROBERT B KRAUTER Burial Permit Clerk ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 26th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 26th 1920, to July 26th 1920; that I saw him alive on July 26th 1920. and that death occurred, on the date stated above, at 2 40 p.m.

The CAUSE OF DEATH* was as follows:

Prematurity

& monster gestation

(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY ... (Secondary)

(Duration) ... yrs. ... mos. ... da.

(Signed) ... M. D.

July 26th, 1920. (Address) 2006 N. Rose St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross. DATE OF BURIAL, July 26th 1920

20-UNDERTAKER Leo D. Burke ADDRESS Northern Ave

Important. See instructions on back of certificate.

Clifford Gest.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45130 HEALTH DEPARTMENT—CITY OF BALTIMORE D45130

CERTIFICATE OF DEATH. X 37

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mercy Hospital St.: 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifford Gest

(a) RESIDENCE. No. Fort Dupont St., Md Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montana

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Ethel

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Mercy Hospital (Address) Eutaw St.

15 Filed JUL 28 1920 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1920

17

I HEREBY CERTIFY, That I attended deceased from July 16, 19.., to July 25, 1920, that I last saw h alive on ..., 19..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not Know

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic

(Signed) ... M. D.

, 19 (Address) Lauford Md Sanitarium

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md	July 26 1920
20 UNDERTAKER	ADDRESS
John F Denny	715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045131 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045131

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hosp St.; 22 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard P. Thomas

(a) RESIDENCE. No. 523 S. Fremont Ave. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Woodworker

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. J. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Christopher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed JUL 26 1920 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1920

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1920, to July 24, 1920, that I last saw him alive on July 23, 1920, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 1 yrs. (?) mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. J. Rigney, M. D.

7-24-20, 19 (Address) Municipal Tuberculosis Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	July 26 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 1053 W. Balto St

CAUSE OF DEATH in plain terms, so that a definite and correct classification may be made. See instructions on back of certificates.
TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

2045132 HEALTH DEPARTMENT—CITY OF BALTIMORE 2045132

CERTIFICATE OF DEATH. X 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1353 Ward ST.; 21 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sadie Hebron

(Residence in Baltimore: No. 1353 Ward St.; ....yrs., 7 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F.	C	

6-DATE OF BIRTH, Nov. (Month) 25 (Day), 1912 (Year)

7-AGE, ...yrs. 8 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Howard Co Md

PARENTS.

10-NAME OF FATHER Alex Hebron

11-BIRTHPLACE OF FATHER (State or Country), Howard Co Md

12-MAIDEN NAME OF MOTHER Mary Keely

13-BIRTHPLACE OF MOTHER (State or Country), Howard Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Hebron

(Address) 1408 Carroll St

15- ROBERT F KRAUTER

Filed JUL 26 1920, BURIAL Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 25, 1912 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 23 1912, to July 25 1912, that I saw h... alive on July 25 1912, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Entero Colitis

(Duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary) Athrepsia

(Duration) ....yrs. 7 mos. ....ds.

(Signed) J F Moorwood M. D.

July 25, 1912 (Address) 937 W Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	July 27, 1912
20-UNDERTAKER Brown and Treland	ADDRESS 114 N Schroeder

Check if any. See instructions on back of certificate. important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

045133 HEALTH DEPARTMENT—CITY OF BALTIMORE X 104 045133

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 E. Balto ST.: 6 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elinora Hirowski

(a) RESIDENCE. NO. 1716 E. Balto ST., WARD. Detroit Michigan

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of "

6 DATE OF BIRTH (month, day, and year) Dec 4 - 1919

7 AGE: Years — Months 7 — Days 26 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work " " 000

(b) General nature of Industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Mich

PARENTS

10 NAME OF FATHER Wladyslaw Hirowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Marta Smitkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant W. Hirowski (Address) 1716 Balto -

15 Filed JUL 26 1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1920

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1920, to July 26, 1920, that I last saw h.er alive on July 26, 1920, and that death occurred, on the date stated above, at 8.15 a. m.

The CAUSE OF DEATH* was as follows:

Acute Entero-Colitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) improper feeding

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. J. Cominsano, M. D.

, 19 (Address) 7 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ost. Evangelical — DATE OF BURIAL: 7/27 19

20 UNDERTAKER: Jos. Fialkowski 1611 Eastern ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

145134

HEALTH DEPARTMENT—CITY OF BALTIMORE

151

145134

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 N. 33rd St.: 13 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Killum Davis

(a) RESIDENCE. No. 506 N 33rd St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24/1920

7 AGE: Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Harry C Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Arkansas

12 MAIDEN NAME OF MOTHER Ida E Parkinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Harry C Davis
(Address) 506 N 33rd St

15 Filed JUL 26 1920, 19 ROBERT B [illegible] Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1920

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1920, to July 26, 1920, that I last saw h[illegible] alive on July 25, 1920, and that death occurred, on the date stated above, at 2-A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

Fromen Osak not Closed

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? C

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. L. Fair M. D.

. 19 (Address) 12 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	July 27 1920

20 UNDERTAKER: Cheneworth & Son ADDRESS: Calvert St

CAUSE OF DEATH must be plainly stated, and the certificate must be properly filled out. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45135 HEALTH DEPARTMENT—CITY OF BALTIMORE D45135

CERTIFICATE OF DEATH. 105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1217 William ST.: 24 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Mueller

(a) RESIDENCE. NO. 1217 William ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 15-1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 090

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John. Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Clara R. Ingalls

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pikesville Md

14 Informant — Mrs Mueller
(Address) 1209 William St

15 Filed JUL 26 1920 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1920

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1920, to July 25, 1920, that I last saw h[illegible] alive on July 25, 1920, and that death occurred, on the date stated above, at 4. P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. 2 hrs.

CONTRIBUTORY (Secondary) Acute Gastro Enteritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. Mueller M. D

July 26 1920 (Address) 1209 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	July 28 1920
20 UNDERTAKER M. J. Flynn	ADDRESS 1432 Light St

CAUSE OF DEATH is plain terms, so that it may be understood on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045136

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

1045136

CERTIFICATE OF DEATH.

25-104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 Curtis Ave ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lidia E Langvill

(a) RESIDENCE. No. 1509 Curtis Ave ST.. ..... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 12-192

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wilbur Langvill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER M. Brumbart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wilbur Langvill
(Address) 1509 Curtis Ave

15 Filed JUL 26 1920 ROBERT E. LAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1920

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1920, to July 26, 1920, that I last saw h.. alive on July 25, 1920, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Entero Colitis

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Hamman Eng Lee, M. D.

, 19 (Address) 635 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. A.A.	July 27 1920
20 UNDERTAKER M. L. Flynn	ADDRESS 1425 Light St

CAUSE OF DEATH to plain terms, so that a non-professional person can understand it. TION is very important. See instructions on back of certificates.

Harry W Schuck. ✓

L 45137 HEALTH DEPARTMENT—CITY OF BALTIMORE L 45137

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 537 Hillen St. 18 Ward) H-U

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry W Schuck

(Residence in Baltimore: No. 537 Hillen St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Oct 24, 1878.
(Month) (Day) (Year)

7-AGE, 41 yrs. 9 mos. ds.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Broker
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John C Schuck

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Nickman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Harry W Schuck

(Address) 537 Hillen St

15-JUL 26 1920 ROBERT E LAUTER
Filed....., 191... STATE REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 24, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Louis Von Tagen M. D.
(Coroner.)

6/26, 1920 (Address) 1400 Gilmore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
1st German	July 27, 1920
20-UNDERTAKER	ADDRESS
Peter Nicolaus	3046 Eastern Ave

N.B.—ENTRIES must be made in plain terms, so that it may be properly classified. Each statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45138

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45138

CERTIFICATE OF DEATH.

REGISTERED NO. 20120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1941 Edmondson Avenue ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella E. Devon

(a) RESIDENCE. No. 1941 Edmondson Avenue ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 70 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Devon

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Patrick Rooney

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen ------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Annie Devon
(Address) 1941 Edmondson Ave.

15 Filed JUL 27 1920 19 G H Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 19 20

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to July 27, 1920,
that I last saw h... alive on July 26, 1920,
and that death occurred, on the date stated above, at 5:40 a.m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) Incertain yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ... M. D.

7/26, 19 (Address) 2310 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	7/27 1920
20 UNDERTAKER	ADDRESS
Henry W. Hears & Son 805	N. Calvert St.

CAUSE OF DEATH ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45139 D45139

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2132 Fidelity Av ST.; 70 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Haas

(Residence in Baltimore: No. 2132 Fidelity Av St.; 68 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, April 19, 1848 (Month) (Day) (Year)

7-AGE, 72 yrs. 3 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work nothing
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, dont know

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Mary Schafer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Haas.

(Address) 526 E 39 st

15- JUL 27 1920 G. H. Cress

Filed....., 191.... Registrar.

CAUSE OF DEATH. Information important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 25, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 1920, to July 25, 1920, that I saw her alive on July 21, 1920, and that death occurred, on the date stated above, at 8.45 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(Duration) yrs. mos. 6 ds.

(Signed) O. B. Wilson M. D.

July 26, 1920 (Address) 1733 N Wolfe St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, July 28 1920

20-UNDERTAKER Josiah Lefevre ADDRESS 1600 W North Ave

Spec.—6-9-19—H. P. Co.—1000 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45140

91-D45140

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 Tramore Road ST. 27 WARD)

2-FULL NAME Rosina F Stuerken

(a) RESIDENCE. No. 216 Tramore Road ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Herman F Stuerken

6 DATE OF BIRTH (month, day, and year) Nov 18th 1853

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adam Boch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Stein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ernest A. Stuerken

(Address) 140 St John st Stonestown Sta C

15 Filed JUL 27 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1920

17 I HEREBY CERTIFY, That I attended deceased from July 15th 1920 to July 25 1920

that I last saw h.. alive on July 17 1920

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Deformans

10 years.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Confined to house 3 days

Did an operation precede death? No Date of

Was there an autopsy? No Findings

What test confirmed diagnosis?

(Signed) Arthur W. Hedrich, M. D.

, 19 (Address) 404 Gunter Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Immanuel Lutheran Cemetery Govanstown	July 28 1920

20 UNDERTAKER ADDRESS

George Schilling & Sons 1126 E Monument St

CAUSE OF DEATH to be plainly written, so that it may be readily understood. Information on back of certificates. TION is very important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

D45141

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45141

CERTIFICATE OF DEATH.

REGISTERED NO. C 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 W Preston ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Banks

(Residence in Baltimore: No. 311 W Preston St.; Same yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, Aug 8th, 1977 (Month) (Day) (Year)

7-AGE, 47 yrs. 11 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook 021
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), not known

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josiah Boone

(Address) 311 W Preston St

15-

Filed JUL 27 1920, 191.... G. H. Croce. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 26th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 8 1920, to July 26 1920, that I saw h[illegible] alive on July 25 1920, and that death occurred, on the date stated above, at 7 20 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

not known (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) diabetic Gangrene

of foot (Duration) yrs. 3 mos. ds.

(Signed) Samuel A Davis M. D.

July 26th 1920 (Address) 937 Madeira St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Laurel Cemetery	July 28th, 1920.
20-UNDERTAKER	ADDRESS
Philip B Pye	1025 Wilkens Ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bkt.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45142 — 502 D45142

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 N Elwood ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F. Albers

(Residence in Baltimore: No. 511 N Elwood St.) (38 yrs., 5 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, Dec 7, 1858 (Month) (Day) (Year)

7-AGE, 61 yrs. 7 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Butcher
(b) General nature of industry, business, or establishment in which employed (or employer): 01 3

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Dont Knit

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elizabeth Albers

(Address) 511 N. Ellwood

15- JUL 27 1920 G. H. Grese.

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 25, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 12 1920, to July 25 1920, that I saw h[im] alive on July 25 1920, and that death occurred, on the date stated above, at 8.50 P. m.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene of Foot

(Duration) yrs. 3 mos. ds.

(Signed) H. E. Myers M. D.

July 27, 1920 (Address) 1301 N Pat Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, July 28, 1920.

20-UNDERTAKER J Kerwig & Co ADDRESS 2005 Albans

Circular of information important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~D~~ 45143 ~~D~~ 45143 ~~D~~ 45143

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1332 Woodyear ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phillip A Hall

(a) RESIDENCE. NO. 1332 Woodyear ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov. 3, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
		8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Phillip Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S. A. Co. Md.

12 MAIDEN NAME OF MOTHER Roberta Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Phillip Hall 1332 Woodyear St

15 Filed JUL 27 1920 G. H. Crese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1920

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1920, to July 25, 1920, that I last saw h[illegible] alive on July 25, 1920, and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis 7

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Rickets 3 C

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Wm H Wright M. D.

July 26, 1920 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 27 1920

20 UNDERTAKER ADDRESS

George H. Holland 1631 Pennsylvania Ave

Fallsway

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45144

CERTIFICATE OF DEATH.

170 D45144

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3312 Colgate ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Tontrup

(a) RESIDENCE. No. 3312 Colgate ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Frederick Tontrup

6 DATE OF BIRTH (month, day, and year) Sept 25 48

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Horstman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick Tontrup
(Address) 3312 Colgate

15 Filed JUL 27 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1920

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1920, to July 26, 1920, that I last saw h[illegible] alive on July 24, 1920, and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Acute Insufficiency,

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chron. Interstitial Nephritis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Own home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical urine.

(Signed) J. K. Insley, M. D.

, 19 (Address) 2458 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	July 27 1920
20 UNDERTAKER Philip Hennig	ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms. Accuracy in this item is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45145

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45145

CERTIFICATE OF DEATH.

135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto. Gen. Hospital St.) 22 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Bailey.

(a) RESIDENCE. No. 616 Eutaw ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored.	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Bailey.

6 DATE OF BIRTH (month, day, and year) Unknown 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32 yrs.	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant George Bailey his X mark
(Address) 616 Eutaw St.

15 Filed JUL 27 1920 G. H. Gre[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-25 - 1920

17 I HEREBY CERTIFY, That I attended deceased from 7-25, 1920, to 7-25, 1920, that I last saw her alive on 7-25-, 1920 and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:

Premature separation of normally implanted placenta

(6 hrs) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-25-20

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) J. C. Ponte Jr. M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lot 1	July 28 1920
20 UNDERTAKER Robt W Henderson	ADDRESS 1502 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14 1748 D45146

532-45146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.; 20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernadette Levering

(a) RESIDENCE. No. 306 S. Garrison Lane ST.,

(Usual place of abode) WARD.

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8, 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Howard Levering

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Annie Winters

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Hospital Record
(Address) J. H. H.

15 Filed JUL 27 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1920

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1920, to July 26, 1920, that I last saw h.r alive on July 26, 1920, and that death occurred, on the date stated above, at 1:05 a. m.

The CAUSE OF DEATH* was as follows:

Acute lymphoblastic leukemia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood picture

(Signed) Harold L. Higgins, M. D.

7/26 1920 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	July 28 1920
20 UNDERTAKER	ADDRESS
John J. Fields	1200 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. [illegible] TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45147 D45147 D45147

CERTIFICATE OF DEATH.

5 — 40 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Home ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Bailey

(Residence in Baltimore: No. Hebrew Home / Hayward & Fayette St.: 19 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Unknown —, 1855
(Month) (Day) (Year)

7-AGE, 65 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ...000...
(b) General nature of industry, business, or establishment in which employed (or employer) ...Housewife...

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Baltimore St

15- Filed JUL 27 1920 191... G. H. Grese. Registrar.

CAUSE OF DEATH in plain terms. [illegible] important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 27, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 17th 1920, to July 27th 1920, that I saw h[illegible] alive on July 27th 191..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs...mos...ds.

(Signed) Ben Jacks M. D.

July 27, 1920 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ...yrs. ...mos. 10 ds. In the State 17 yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 111 Aisquith st

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herring Run — DATE OF BURIAL, July 27, 1920

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balt

D45148

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 / D45148

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 206 N. Fulton Ave ST.: 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Dr. John G. Stiefel

(Residence in Baltimore: No. 206 N. Fulton Ave St.: 24 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 SINGLE, (MARRIED) WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: May (Month) 17 (Day), 1874 (Year)

7 AGE: 46 yrs. 2 mos. 14 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): College Hill

PARENTS

10 NAME OF FATHER: John G. Stiefel

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emma Meiter

13 BIRTHPLACE OF MOTHER (State or country): New York

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs John G. Stiefel

(Address) 206 N. Fulton Ave

15 Filed JUL 27 1920, 191 G. H. Grese. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 26 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June, 1916, to July 26 1920, that I saw h[im] alive on July 26 1920, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure
Pulmonary Edema
(Duration) ..... yrs. ..... mos. 7 ds

Contributory (SECONDARY) Chronic Endocarditis
(Duration) 1½ yrs. ..... mos. ..... ds.

(Signed) Geo. McGean M. D.
July 27, 1920 (Address) 20 E Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. | In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Druid Ridge | DATE OF BURIAL: July 29 1920

20 UNDERTAKER: George W. Tellis | ADDRESS: 537 N. Fremont

N. B.-Every item of information should be carefully supplied. AGE should be stated in years and months if less than one year, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45149

D 45149

65

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 N. Fremont ST.; 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosanna Smith

(a) RESIDENCE. NO. 321 N. Fremont ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home 795

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City (State or country)

PARENTS

10 NAME OF FATHER Henry Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christiana Waidner

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant John Smith

(Address) 321 N Fremont Av

15 Filed JUL 27 1920 G. H. Crese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1920

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1920, to July 24, 1920, that I last saw her alive on July 24, 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(Softening of brain)

(duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(Indefinite) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. Grod Strauss Jr., M. D.

7/27 1920 (Address) 1935 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 28 1920
20 UNDERTAKER Geo W Little	ADDRESS 531 N. Fremont Av

CAUSE OF DEATH. ATTENTION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 45150

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45150

CERTIFICATE OF DEATH.

81

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5824 York Road St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Barr Scholl

(Residence in Baltimore: No. 1005 W Lanvale St.; 45 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH. Dec. (Month) 4 (Day), 1846 (Year)

7-AGE, 73 yrs. 7 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Stone
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, Amos Barr

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER Martha A. Smith

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Geo. Scholl D.D.

(Address) 1005 W Lanvale St

15-

Filed JUL 27 1920 GH Grese Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 25 1920, to July 25 1920, that I saw her alive on July 25 1920, and that death occurred, on the date stated above, at 4.20 P m.

The CAUSE OF DEATH* was as follows:

Indigestion Fatal syncope

1/2 hour.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo H Hocking M. D.

7/25, 1920 (Address) 5330 York Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park

DATE OF BURIAL. July 28, 1920

20-UNDERTAKER Geo W Little

ADDRESS 531 N Eutaw

D45151 HEALTH DEPARTMENT—CITY OF BALTIMORE D45151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital St. 20 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rev. Cuny M. Corbor M. McCarl

(Residence in Baltimore: No. 236 Collins Ave. Irvington St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month), 1 (Day), ... (Year)

7-AGE, 57 yrs. 7 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Drill press
(b) General nature of industry, business, or establishment in which employed (or employer)..... Operator 063

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Geo. McCarl

11-BIRTHPLACE OF FATHER (State or Country). Balto

12-MAIDEN NAME OF MOTHER Mary Johnson

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno P. Riley

(Address) 2014 W. Saratoga

15- Filed JUL 27 1920, 191.... G. H. Grese, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmn. Tuberculosis (Bleeding)

Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Emphysema (1 yr.)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. Wiley M. D.
(Coroner)

July 26, 1920 (Address) 1600 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, 7/28/ ....., 19....

20-UNDERTAKER Jos B Cook — ADDRESS 1005 W Balto

N. B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D45152

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45152

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. German Aged Home ST.; 20 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Bugiel

(Residence in Baltimore: No. German Aged Home St.; 63 yrs.,.....mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Oct (Month) 15th (Day), 1847 (Year)

7-AGE, 72 yrs. 9 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Johann Bugiel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Cora Schwinn

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) German Aged Home Records

(Address) Baltimore and Lyndhurst Sts.

15- JUL 27 1920 G. H. Grese.

Filed....., 191.....

Registrar.

CAUSE OF DEATH must be plainly and fully stated. Be particular and important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 24 1920, to July 25 1920, that I saw h.. alive on July 25 1920, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Julius Hauff M. D.

7/26/20 191... (Address) 1143 W Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Loudon Park Cem	July 27, 1920
20-UNDERTAKER Joseph P. Cook	ADDRESS 1003 W. Baltimore St.

D 45153

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 45153

CERTIFICATE OF DEATH.

1 169

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Off Hawkins Point. ST.: 25 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Franco Papalardo.

(Residence in Baltimore: No. Palermo, Italy St.: yrs.—— mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	ingle.

6-DATE OF BIRTH, August 8th. 1887., 1 ..... (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
32 yrs. 11 mos. 14 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... 2nd. Engineer 030
(b) General nature of industry, business, or establishment in which employed (or employer)..... S/S. Castelporziano.

9-BIRTHPLACE, (State or Country). Palermo, Italy.

PARENTS.

10-NAME OF FATHER, Pablo Papalardo.

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER, Loiacono Marianna.

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. Schiaffino.

(Address) 417 E. Baltimore St.

15-

Filed JUL 27 1920, 191..... G. H. Grese. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 23rd. 1920. Found floating July 26th. 1920, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Drowned while in swimming.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto Reinhardt M. D. (Coroner.)

July 27, 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Palermo, Italy.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Lorraine Cemetery	27, 1920
20-UNDERTAKER	ADDRESS
H. A. Moore & Co.	510 N. Calvert St.

N. B. Every item in the CAUSE OF DEATH in plain terms, so that it may be properly classified. Give address of informant. See instructions on back of certificate.

Spec. 6-9-19 H. F. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45154 — 1042 D 45154

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 S. Clinton St. St.: 26 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah V. Schissler

(a) RESIDENCE. No. 724 S. Clinton St., 26 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. THION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 4-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer): ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City Md.

PARENTS

10 NAME OF FATHER: Joseph Schissler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Saeto Md.

12 MAIDEN NAME OF MOTHER: Hazel Reinig

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Joseph Schissler 724 S. Clinton St.

15 Filed JUL 27 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26. 1920

17 I HEREBY CERTIFY, That I attended deceased from July 25 1920, to July 26 1920, that I last saw h[er] alive on July 25 1920 and that death occurred, on the date stated above, at 1.05 A.M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M. J. McAvoy, M. D.

, 19 (Address) 739 S. Edward ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	July 27 1920

20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Woodyard

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45155

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1042 45155

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 26 ST., WARD)

2-FULL NAME Madeline Larsen

(a) RESIDENCE. No. 333 S. 13th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 10 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 22-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 000

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles Larsen

11 BIRTHPLACE OF FATHER (city or town) (State or country): ★ Sweden

12 MAIDEN NAME OF MOTHER: Anna Trush

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant: (Charley Larsen, father)
(Address): 333 S. 13th St.

15 Filed JUL 27 1920 G. H. Grace Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1920

17 I HEREBY CERTIFY, That I attended deceased from July 25. 1920. to July 26. 1920. that I last saw her alive on July 26. 1920. and that death occurred, on the date stated above, at 10:40 a. m.

The CAUSE OF DEATH* was as follows:

acute ileo-colitis

(duration) — yrs. — mos. 17 ds.

CONTRIBUTORY (Secondary): acute nephritis

(duration) — yrs. — mos. ? ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? yes, urine exam.

What test confirmed diagnosis? autopsy findings

(Signed) B. Macfarlane, M. D.

July 26 1920 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	July 28 1920
20 UNDERTAKER: Lilly & Zeiler	ADDRESS: 403 S. Wolfe

CAUSE OF DEATH in plain terms. Indefinite and unscientific terms and abbreviations may not be used. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45156 HEALTH DEPARTMENT—CITY OF BALTIMORE D45156

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Rosedale Ave. E. of Park Heights St. 14 WARD) 80

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca M. Attenheimer

(a) RESIDENCE. No. 1634 Linden Ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? 59 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Attenheimer

6 DATE OF BIRTH (month, day, and year) April 11 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar Mfg.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER Moses Attenheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Babette Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant L Attenheimer (Address) 1104 Linden Ave

15 Filed JUL 27 1920 G. H. Gretz Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26th 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 20 1920, to July 26 1920, that I last saw alive on July 26 1920, and that death occurred, on the date stated above, at 6 30 p.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Block (Stoke Adams) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Julius Friedenwald, M. D.

, 19 (Address) 1013 Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chebt Shalom	July 28 1920

20 UNDERTAKER Hart Goodheim ADDRESS 1180 Mt Royal

THIS is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45157

141313 D-45157

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 78 D45157

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Reed

(a) RESIDENCE. NO. Bengies Md. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	2.	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Daniel Reed

11 BIRTHPLACE OF FATHER (city or town) Bengies (State or country) Md

12 MAIDEN NAME OF MOTHER Hannah Parks

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant J. H. H. Records
(Address)

15 Filed JUL 27 1920 Registrar G. H. Grese.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 — 1920

17

I HEREBY CERTIFY, That I attended deceased from June 3 —, 1920, to July 24, 1920, that I last saw h.. alive on July 24, 1920, and that death occurred, on the date stated above, at 345 P m.

The CAUSE OF DEATH* was as follows:

Malignant Endocarditis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) V. R. Mason, M. D.

, 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet M. E. Church	July 27th 1920
20 UNDERTAKER	ADDRESS
Emmert & Wright	1361 W. Carey St.

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45158 D45158

CERTIFICATE OF DEATH.

X 45

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital WARD) 25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Chas. Bachtell

(a) RESIDENCE. NO. Smithsburg Md WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11. 4. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Dont Know

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know.

14 Informant Mollie Belaughter (Address) Smithsburg Md

15 Filed JUL 27 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1920

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1920, to July 26, 1920, that I last saw him alive on July 26, 1920, and that death occurred, on the date stated above, at 7.05 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma - Head of pancreas

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Intestinal hemorrhage

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 19

Was there an autopsy? No

What test confirmed diagnosis? Exploratory Operation

(Signed) Enoch H Williams, M. D.

, 19 (Address) St Agnes Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Smithsburg Md	July 29 1920

20 UNDERTAKER ADDRESS

Thurmont Md Chestnut St

(CAUSE OF DEATH in plain terms, so that it may be understood by persons not physicians. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45159 HEALTH DEPARTMENT—CITY OF BALTIMORE D45159

103

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 W. Read ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a bospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mirtha J Johnson,

(a) RESIDENCE. NO. 16 W Read ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Leagth of residence in city or town where death occurred 16 yrs. 7 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: School Girl

6 DATE OF BIRTH (month, day, and year) Dec 26, 1909

7 AGE — Years: 10 — Months: 7 — Days: 29 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Child

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Gabriel H Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Martha J Franklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Gabriel H Johnson
(Address): 16 W Read St

15 Filed JUL 27 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 1920

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1920, to July 26, 1920, that I last saw h[illegible] alive on July [illegible], 1920, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

DCB

Acute Gastritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 16 W Read

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) W H Wright M. D.

July 27 1920 (Address) 1309 Pedestrian St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: July 28 1920

20 UNDERTAKER: Samuel T Hensley

ADDRESS: 578 N Bridle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Early symptoms are of importance. Name contagious diseases. Deaths from violence must state MEANS and NATURE of INJURY, and whether ACCIDENTAL, SUICIDAL or HOMICIDAL. Deaths during childbirth must state DURATION of PREGNANCY and whether CHILD was BORN ALIVE. Deaths from cancer must state DURATION and LOCATION. Deaths from tuberculosis must state LOCATION. Deaths from any form of heart disease must state whether there was EDEMA or CYANOSIS. Deaths from apoplexy must state whether there was PARALYSIS. Deaths from convulsions must state AGE of ONSET. Deaths from old age must state CONTRIBUTORY CAUSES. Deaths of infants must state whether BORN ALIVE or STILLBORN, and whether LIVED or HOW LONG. Deaths of females must state whether PREGNANT or PUERPERAL. Deaths from accident, violence or casualty must state WHERE and HOW INJURY was received. Deaths from poisoning must state NAME, MANNER and DOSE of POISON. Deaths from operations must state NATURE of OPERATION and DATE. Deaths from fevers must state DAY of ILLNESS. Deaths from diphtheria must state whether CULTURE was made. Deaths from tumor must state whether BIOPSY was made. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45160

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45160

150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1038 W Lemmon ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Stock

(a) RESIDENCE. No. 1038 W Lemmon ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25, 1920

7 AGE — Years: — Months: — Days: 2 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Joseph a Stock

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mary Walz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Joseph A Stock 1038 Wilmore ave

15 [illegible] JUL 27 1920 ROBERT F [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1920

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1920, to July 27, 1920, that I last saw h[illegible] alive on July 27, 1920, and that death occurred, on the date stated above, at 2 a m

The CAUSE OF DEATH* was as follows:

Mortus Cerebralis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

July 27 1920 (Address) 1720 E 25 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 27 1920
20 UNDERTAKER	ADDRESS
Louis J Hermann	325 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45161 HEALTH DEPARTMENT—CITY OF BALTIMORE D45161

CERTIFICATE OF DEATH

1-PLACE OF DEATH Franklin Square Hospital 137 REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Leasure

(a) RESIDENCE. No. 1362 Calhoun ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Leasure

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 38 Months Unknown Days Unknown If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Phillip Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert County

12 MAIDEN NAME OF MOTHER: Gertrude Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert County

14 Informant: William Leasure (Address) 1362 Calhoun St

15 Filed JUL 27 1920 19 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 24 1920

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1920, to July 24, 1920, that I last saw h[illegible] alive on July 24, 1920 and that death occurred, on the date stated above, at 8-20 p.m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Yellow Atrophy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms and findings

(Signed) N. T. Lombardi, M. D.

, 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: July 27 1920

20 UNDERTAKER: Edw. Kriggold. — ADDRESS: 1415 N. Caroll

CAUSE OF DEATH must be plainly written, and all questions answered so far as possible. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45162 HEALTH DEPARTMENT—CITY OF BALTIMORE D45162

CERTIFICATE OF DEATH. 18

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1400 Ashland Ave. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Bertha Wilson

(a) RESIDENCE. NO. 1400 Ashland Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 1 mos. 27 ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Information desired in every case. Do not use abbreviations or terms not generally understood. OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): May 31, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Wesley E. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Florence Baines

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Phila Pa.

14 Informant: Wesley E. Wilson (Address) 1400 Ashland Ave

15 Filed JUL 27 1920 ROBERT F. BRAUNER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1920

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1920, to July 27, 1920.

that I last saw her alive on July 27 1920

and that death occurred, on the date stated above, at 11.15 A. m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. Gill Hall, M. D.

July 7 1920 (Address) 1617 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 28 1920

20 UNDERTAKER: Mr. Mrs John H Seufel

ADDRESS: 801 W. Fayette

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48163 HEALTH DEPARTMENT—CITY OF BALTIMORE D48163

6. CERTIFICATE OF DEATH. 628

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2413 Fairmount Ave (St.) (Ward) 6

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonora L. Gutzinger

(a) RESIDENCE. NO. 2413 Fairmount Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Wt.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 8 1897

7 AGE: Years 23 — Months 5 — Days 18 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jos Gutzinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Anna M. Fertig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Anna M. Gutzinger
(Address) 2413 Fairmount Ave

15 Filed JUL 27 1920 ROBERT E LEAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1920.

17 I HEREBY CERTIFY, That I attended deceased from Feb 7- 1920. to July 26. 1920. that I last saw h alive on July 25. 1920. and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fair Haven

Did an operation precede death? — Date of —

Was there an autopsy? T. B. Test

What test confirmed diagnosis?

(Signed) Isa Thurston Blades, M. D.

27. 19 (Address) 43 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: 7/29 1920

20 UNDERTAKER: George J. Ruth ADDRESS: 1735 Harford Ave.

CAUSE OF DEATH is plain terms, so that it may be understood by persons not familiar with technical terms. See instructions on back of certificates.
TION is very important.

D45164 HEALTH DEPARTMENT—CITY OF BALTIMORE D45164

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1607 E North Ave ST.; 8 WARD) REGISTERED No. C 172

2-FULL NAME Andrew E. Smith Jr (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1607 E North Ave St.; yrs., 10 mos. 10 ds.) 24

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, Sept (Month) 6 (Day), 1909 (Year)

7-AGE, 10 yrs. 10 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), city

PARENTS.

10-NAME OF FATHER, Andrew E. Smith Sr

11-BIRTHPLACE OF FATHER (State or Country), city

12-MAIDEN NAME OF MOTHER Barbara M. McCrank

13-BIRTHPLACE OF MOTHER (State or Country), city

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew E. Smith Sr

(Address) 1607 E North Ave

15- Filed JUL 27 1920, 191 ROBERT B KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 27 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism fall
Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
(Coroner)
7-27-20, 191... (Address) 19 E Pleasant

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cemetery DATE OF BURIAL, July 29 1920

20-UNDERTAKER, H A Eichner & Sons ADDRESS, North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D45765 — 79 D45765

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 Haywood ave ST. 27 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fred L Schmidt

(Residence in Baltimore: No. 416 Haywood ave St.; 1 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Oct (Month) 24th (Day), 1867 (Year)

7-AGE, 52 yrs. 9 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Baker 003
(b) General nature of industry, business, or establishment in which employed (or employer). Baking Handling bread

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma A Schmidt

(Address) 416 Hayward Ave

Filed JUL 27 1920, 191.. ROBERT B HEAUTER Registrar.

Burial Permit 31828

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 26th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 14 1920, to July 26 1920, that I saw him alive on July 25 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) 4 yrs. mos. ds.

(Signed) Chas. B. Eutsor M. D.

7-26, 1920 (Address) Park Hgts & Smith ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem — DATE OF BURIAL, July 29, 1920

20-UNDERTAKER W J Tuckwell Son — ADDRESS N Pa

important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

1045166 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045166

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1808 Hennemann Ave ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wiegand Christopher Stoll

(a) RESIDENCE. No. 1808 Hennemann Ave ST., 8 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of ~~(or) WIFE of~~ Barbara Josepheck

6 DATE OF BIRTH (month, day, and year) July 11, 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32		22	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Telephone Operator

(b) General nature of industry, business, or establishment in which employed (or employer) Private switchboard

(c) Name of employer Johns Hopkins Med. School

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Wiegand Chas. Stoll

11 BIRTHPLACE OF FATHER (city or town) Marburg. (State or country) Germany.

12 MAIDEN NAME OF MOTHER Annie B. Graft.

13 BIRTHPLACE OF MOTHER (city or town) Unknown. (State or country) Iowa

14 Informant Barbara J. Stoll (wife) (Address) 1808 Hennemann. Ave.

15 Filed JUL 27 1920 ROBERT P. BRAUTIGAM Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1920

17 I HEREBY CERTIFY, That I attended deceased from July 15 1920 to July 26 1920.

that I last saw him alive on July 26 1920.

and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

approximate (duration) 3 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? X-ray. Sputum anal. +.

(Signed) Laurence B. Chenoweth M. D.

7/26. 1920 (Address) 725 N. Carey Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	July 28 20
20 UNDERTAKER	ADDRESS
Wm T. Hartley	844 Fairfield

CAUSE OF DEATH in plain terms, so that a stranger can understand. Do not use abbreviations or technical terms. Consult physician if necessary. Information required in items 16 to 20, inclusive, is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

This man was a patient at the Maryland State Tuberculosis Sanatorium from April 7, 1920, July 12, 1920. Except for these dates, he has always been a resident of Baltimore.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045167 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045167

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 Eastern Ave St. 3 rd- Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME KATHARINE T. LOTZ,

(a) RESIDENCE. No. 819 Eastern Ave St. 3 rd- Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female,	White,	Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 15-1919.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child, 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.,

PARENTS

10 NAME OF FATHER Leo Lotz,

11 BIRTHPLACE OF FATHER (city or town) Baltimore, (State or country) Md.

12 MAIDEN NAME OF MOTHER Frances Sczepanek,

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) Md.,

14 Informant Leo Lotz, (Father)
(Address) # 819 Eastern Ave.

15 Filed JUL 27 1920 ROBERT F. LAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUL 26 1920

17 I HEREBY CERTIFY, That I attended deceased from July 20, 19 20, to July 26, 19 20, that I last saw h— alive on July 24, 19 20, and that death occurred, on the date stated above, at 8.00 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. Valentine, M. D.

July 26, 19 20 (Address) 16 V Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	July 28" 1920
20 UNDERTAKER	ADDRESS
W. F. Sadowski	905 S. Ann

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Magdalen Jankowiak

HEALTH DEPARTMENT—CITY OF BALTIMORE

L45168 L45168

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Magdalen Jankowiak ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 2602 Hudson St

(a) RESIDENCE. NO. 2602 Hudson ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 05 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Antonio Jankowiak

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Szczepanik

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Antoni Jankowiak
(Address) #2602 Hudson St

15 Filed JUL 27 1920 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/28 1920

17 I HEREBY CERTIFY, That I attended deceased from August 24 1920, to August 28, 1920, that I last saw h[illegible] alive on August 28, 1920, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis & Intes colitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Asthenia & Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) Thos H Ambrose, M. D.

July 29 1920 (Address) 1623 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	July 29 1920
20 UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Ann

CAUSE OF DEATH must be plainly written, and all items answered. See back of certificates.
TION is very important. See instructions on back

Spec.—8-24-14—M. & T.—2600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45169 104 D45169

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 905 N Madeira ST.; 7 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Peter

(Residence in Baltimore: No. 905 N Madeira St.; 44 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, ... Jan (Month) 6 (Day), 1880 (Year)

7-AGE, ... yrs. 6 mos. 21 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Servant girl
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Joseph Peter

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Barbara Kachel

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos Peter

(Address) 905 N Madeira St

15-

Filed JUL 28 1920, 191.....

C. H. Grese. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 26 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 24 1920, to July 26 1920, that I saw her alive on July 26 1920 and that death occurred, on the date stated above, at 11:45 P m.

The CAUSE OF DEATH* was as follows:

..... Uremic Convulsions

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) William J Kerr M. D.

July 27, 1920 (Address) 847 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer | DATE OF BURIAL, July 28 1920

20-UNDERTAKER Frank Cochran | ADDRESS 1911 Baltimore

Cases must be reported within 24 hours after death. See instructions on back of certificate. Every question must be answered if possible. Omissions cause delay and are important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45170

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 608 Bruce ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Carter

(a) RESIDENCE. NO. 608 Bruce ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE — Years: 27 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City Md.

PARENTS

10 NAME OF FATHER: Archer Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Harriet Blackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Daniel Easton
(Address): 916 Pennsa ave

15 Filed JUL 28 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1920

17 I HEREBY CERTIFY, That I attended deceased from June 7 1920 to July 26 1920

that I last saw her alive on July 26 1920

and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical History

(Signed) Frank E. Wagner M. D.

19 (Address) 1006 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 28 192

20 UNDERTAKER: Daniel Easton ADDRESS 916 Penna

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations not allowed. Indefinite terms, such as "Debility," "Old Age," "Infirmity," etc., are not sufficient. Name the disease causing death, or, if unknown, state the symptoms, and how long deceased was sick. If from accident, violence, or casualty, state the nature of the injury, and whether it was accidental, suicidal, or homicidal. If from violence, state how the injury was received, whether in mine, factory, railroad, or elsewhere, and the exact locality. If from childbirth, state whether single or multiple, and whether before, during, or after labor. If from disease of the female organs, state whether recent or of long standing. If from tumor, state whether benign or malignant. If from a contagious disease, state whether case was reported, and to what authority. If from a disease peculiar to infants, state whether the child was born alive, and how long it lived. If from a disease incident to pregnancy, state whether single or multiple, and whether before, during, or after labor. If from a disease of the female organs, state whether recent or of long standing. If from a

Spec.—8-24-14—M. & T.—2000 Bks.

D45171 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D45171

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 Tuxedo ST.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Henry Boston

(Residence in Baltimore: No. 415 Tuxedo St.; 1 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, March (Month) 2 (Day), 1919 (Year)

7-AGE, 1 yrs. 4 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Francis A. Boston

11-BIRTHPLACE OF FATHER (State or Country) Balto. Md

12-MAIDEN NAME OF MOTHER May R. Zellers.

13-BIRTHPLACE OF MOTHER (State or Country), Carroll Co, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis A. Boston

(Address) 415 Tuxedo Av.

15- Filed JUL 28 1920, 191.... C. H. Grace. Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 27 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 19 1920, to July 27 1920, that I saw h— alive on July 26 1920, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Marasmus & Enteritis

(Duration) yrs. 3 mos. 24 ds.

CONTRIBUTORY (Secondary) Marasmus & Enteritis

(Duration) yrs. mos. ds.

(Signed) R. P. Carman M. D.

July 27, 1920. (Address) 1701 N Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn — DATE OF BURIAL, June 28, 1920.

20-UNDERTAKER Horace Burger Son — ADDRESS 3631 Falls Rd.

Spec.—8-24-14—M. & T.—2000 Bks.

D 45172

HEALTH DEPARTMENT—CITY OF BALTIMORE

1208 45172

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 12 South Regiated ST. 3d WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Clinton

(Residence in Baltimore: No. 28 South Bethel St.: 40 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown ....., 1848.
(Month) (Day) (Year)

7-AGE, 72 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Home

9-BIRTHPLACE, (State or Country) Baltimore City

PARENTS.

10-NAME OF FATHER, Samuel Butler

11-BIRTHPLACE OF FATHER (State or Country) Baltimore City

12-MAIDEN NAME OF MOTHER Margaret O—

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Clinton

(Address) 28 S. Bethel St.

15-
Filed JUL 28 1920 191 G. H. Grese.
Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 25 m, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 14 1920, to July 26 1920, that I saw him alive on July 25 1920, and that death occurred, on the date stated above, at 3.15 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) A. H. Broadrick M. D.

July 26, 1920 (Address) 122 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt Zion Cemtry

DATE OF BURIAL, July 28 1920

20-UNDERTAKER Mrs Robt A Mott

ADDRESS 1725 —

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45173.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45173

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3821 Culver St. ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie D. Merryman

(a) RESIDENCE. No. 3821 Culver St. ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 9 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 28, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER Nicholas B. Merryman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Catherine Bridner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Mrs. H. B. Rice

(Address) 3803 Culver St.

15 Filed JUL 28 1920 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1920.

17 I HEREBY CERTIFY, That I attended deceased from July 23 1920, to July 26 1920, that I last saw h[illegible] alive on July 25 1920, and that death occurred, on the date stated above, at 8 45 A. m.

The CAUSE OF DEATH* was as follows: over

General debility

CONTRIBUTORY (Secondary) Arterial Sclerosis (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W Jones M. D.

(Address) 722 Cathedral St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 28 1920.

20 UNDERTAKER Wilbur H Shriver ADDRESS 1018 Edmondson Av

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

D45174

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45174

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 632 Pierce St.; 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Addie Anderson Ward.

(Residence in Baltimore: No. 632 Pierce St.; 44 yrs., 3 mos. 27 ds.)

40

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fe

4-COLOR OR RACE, Black

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Mar'd

6-DATE OF BIRTH, March 27, 1876.
(Month) (Day) (Year)

7-AGE, 44 yrs. 3 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)..... 041

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm H Anderson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Lethia Anderson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Randolph Ward

(Address) 632. Pierce St

15-

Filed JUL 28 1920, 191.....C. H. Cross.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 26, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 26 1920, to July 26 1920, that I saw h.. alive on July 26 1920, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Diabetic Coma.

(Duration).....yrs. 3 mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) H. M. King M. D.

7-27, 1920 (Address) 632 N. Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, W Fairview

DATE OF BURIAL, July 29 1920

20-UNDERTAKER Sam'l H. Chase

ADDRESS 1400 W Mosher

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45175 ✓ 1042 D45175

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 808 Willow ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie A. Lemore

(a) RESIDENCE. No. 808 Willow ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 2. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Gable Lemore

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Alice Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore md

14 Informant Annie Murphy (Address) 808 Willow St

15 Filed JUL 28 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7 27 1920

17

I HEREBY CERTIFY, That I attended deceased from May 20, 1920, to July 25, 1920, that I last saw h. alive on July 20, 1920, and that death occurred, on the date stated above, at 8.15 p. m.

The CAUSE OF DEATH* was as follows:

Acute Ileocolitis

(duration) yrs. mos. 29 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Hornstein, M. D.

7/28. 1920 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	July 28 1920

20 UNDERTAKER William G. Schaffer ADDRESS 1816 Monument St

CAUSE OF DEATH should be stated by the physician in plain English. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45176

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45176

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 1791

CITY OF BALTIMORE: (No. 526 Pierce St. St.) 17 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian McShields

(a) RESIDENCE. No. 526 Pierce St St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 11 mos. 15 ds. How long in U. S., if of foreign birth? 3 yrs. 11 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
fem	col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	11mos	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Hall Deschield~~

(b) General nature of industry, business, or establishment in which employed (or employer) ~~Laborer~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salisbury Md

PARENTS

10 NAME OF FATHER Hall Meschields

11 BIRTHPLACE OF FATHER (city or town) (State or country) Salisbury Md

12 MAIDEN NAME OF MOTHER Kennetta Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Salisbury Md

14 Informant Hall Deschields
(Address)

15 Filed JUL 28 1920 G. H. Grese, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1920

17 I HEREBY CERTIFY, That I attended deceased from July 21st 1920. to July 27th 1920.
that I last saw her alive on July 27th 1920.
and that death occurred, on the date stated above, at 6.55 A m.

The CAUSE OF DEATH* was as follows:

Bronchs Pneumonia
Child had been sick with a cold in head for an indefinite period
(duration) yrs. 7 mos. 6 ds.

CONTRIBUTORY (Secondary) Rickets
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 524 Pierce St.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) W. H. Grant, M. D.

19 (Address) Greene & Franklin Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 28 1920

20 UNDERTAKER Charles B. Jones ADDRESS 21 Pine

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. See reverse side of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45177

CERTIFICATE OF DEATH.

39 D45177

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE. (No. 222 N Pine st. St.: 4 WARD)

2-FULL NAME John H. Powell

(a) RESIDENCE. NO. 222 N Pine st ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colord	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
59				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS
10 NAME OF FATHER John H. Powell
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Dont Know
13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Alice J Powell (Address) 222 N Pine st

15 Filed JUL 28 1920 19 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25- 1920

17 I HEREBY CERTIFY, That I attended deceased from March, 1920, to July 25, 1920
that I last saw him alive on July 24, 1920
and that death occurred, on the date stated above, at 12-N. a. m.
The CAUSE OF DEATH* was as follows:

Cancer of Mouth Tongue & Throat
(duration) since march-1920 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of March 1920
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) W K Gonsuel, M. D.
July 27 1920 (Address) 117 W Saratoga st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	7/29/20.
20 UNDERTAKER	ADDRESS
Charles B. Jones	211 N. Pine

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Blks.

L 45178 HEALTH DEPARTMENT—CITY OF BALTIMORE L 45178

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hosp. REGISTERED NO.....

CITY OF BALTIMORE: (No. 25 ST.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Barreda Turner

(a) RESIDENCE. NO. Lake Station Belto. Co. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Wh	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Caroline Ewell Turner.

6 DATE OF BIRTH (month, day, and year) Jan. 22, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Broker 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer A B. Leach & Co Inc Baltimore, Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Barreda Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md -

12 MAIDEN NAME OF MOTHER Maud Caldwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Robert B. Turner (Address) Lake Station, Belto. Co.

15 Filed JUL 28 1920 C. H. Cross Registrar

CAUSE OF DEATH to be plainly written, without abbreviations. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/27/ 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to July 27, 1920, that I last saw him alive on July 27, 1920, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Typhoid fever, Complicated by Lung Abscess.

Immidiate Cause - Embolus - 45 days - (duration) Sudden — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Typhoid - & Lung Abscess - (duration) yrs. mos. 05 ds.

18 Where was disease contracted If not at place of death? Home -

Did an operation precede death? Yes Date of 7/22/20

Was there an autopsy? No

What test confirmed diagnosis? Operation - Widal Blood Culture

(Signed) W. C. Caldwell - M. D.

19 (Address) St - Agnes Hosp -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	7-29 1920
20 UNDERTAKER Henry W. Keelins & Sons Co	ADDRESS McCulloh & Eutaw

Spec.—3-24-14—M. & T.—2000 Blks.

045-179

HEALTH DEPARTMENT—CITY OF BALTIMORE

045179

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH Hebrew Hospital

REGISTERED No. C.....

CITY OF BALTIMORE: (No. E Monument ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Riddle (Not Named)

(Residence in Baltimore: No. 213 N. Milton Ave. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) X

6-DATE OF BIRTH, July (Month) 25 (Day), 1920 (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 1 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Md Md.

PARENTS.

10-NAME OF FATHER, Guy D Riddle

11-BIRTHPLACE OF FATHER (State or Country), Illinois

12-MAIDEN NAME OF MOTHER Alice Pugh

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Filed JUL 28 1920, 191... ROBERT E KRAUTZ, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3.10 AM 7-25 1920, to 4.10 AM 7-25 1920, that I saw h-er alive on 3.10 AM 7-25 1920, and that death occurred, on the date stated above, at 4.10 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) General Peritonitis 6 months

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry Goldmann M. D.

7-26, 1920. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, JUL 27 1920, 191...

20-UNDERTAKER .....

ADDRESS .....

Commissioner of Health.

17885

important. See instructions on back of certificate.

D45-180 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45180

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. East Falls ave. & Pratt St. 3 WARD) 169 REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown

(Residence in Baltimore: No. —— St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Unk

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 25 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, " "

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eastern Valley Station

(Address) Bank & X

15- JUL 28 1920 ROBERT I. KRAUTER
Filed....., 191.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 27, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Wesleyate (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Wesleyate (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Lyon Dunstan M. D.
(Coroner)

July 27 1920 (Address) 16 E. Eager St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY

DATE OF BURIAL, JUL 27 1920, 19....

20-UNDERTAKER Commissioner of Health, Per WM. F. WOODALL

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of DISEASE important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45181 D45181

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Kestling Aiken

(a) RESIDENCE. No. 1819 ~~Ellen~~ St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	~~Married~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Andrew Kestling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Hospital Records, (Address) New City Hospital

15 Filed ..., 19... ROBERT P. ~~LAMPTER~~ Clerk

Burial Permit Required

JUL 28 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1920, to July 27, 1920, that I last saw him alive on July 27, 1920, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Generalized arterio-sclerosis with residual hemi-plegia (cerebral thrombosis)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) Bozeman, M. D.

7/27/1920 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery Stanford Park	July 28 1920
20 UNDERTAKER	ADDRESS
Henry Hoark Son	1301 E Eager St

CAUSE OF DEATH to plain terms, so that it can be understood by anyone. Read carefully the instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45182 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 151 D 45182

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1311 Holbrook ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip L. Meyers

(a) RESIDENCE. NO. 1311 Holbrook ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 2nd 1919

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Laurence Meyers

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E Faldner

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mr. Laurence Meyers

(Address) 1311 Holbrook St

15 Filed JUL 28 1920 19 ROBERT I. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27th 1920

17 I HEREBY CERTIFY, That I attended deceased from April 28th, 1920, to July 27th, 1920, that I last saw him alive on July 27th, 1920, and that death occurred, on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. M. C. Parker, M. D.

19 (Address) 1114 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 29. 1920
20 UNDERTAKER Henry Hoeck Sons	ADDRESS 1201 E Eager St

CAUSE OF DEATH in plain terms, so that it may be classified. ATTENTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45183

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 45183

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 N. Gilmore ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Parker

(a) RESIDENCE. No. 1111 N. Gilmore ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of mrs

6 DATE OF BIRTH (month, day, and year) July 17 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Royal D. Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Helen McFee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Royal D. Parker
(Address) 1111 N. Gilmore St

15 Filed , 19 ROBERT B. KRAUTER Registrar

Burial Permit Issued JUL 23 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1920

17

I HEREBY CERTIFY, That I attended deceased from July 17 1920, to July 28 1920, that I last saw her alive on July 28 1920, and that death occurred, on the date stated above, at 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Immature

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. J. Thomas Nelson M. D.

, 19 (Address) 1001 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	July 28 1920
20 UNDERTAKER	ADDRESS
Henry Horch Son	1301 E. Eager St

CAUSE OF DEATH to be plainly written, and TION is very important. See instructions on back of certificates.

D45184 HEALTH DEPARTMENT—CITY OF BALTIMORE D45184

CERTIFICATE OF DEATH.

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 803 E Eastern Ave ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Gleason

(Residence in Baltimore: No. 803 E Eastern Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single.

6-DATE OF BIRTH, Oct (Month) 6 (Day), 1914 (Year)

7-AGE, ...yrs. 9 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles Gleason

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Nellie McTaul

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Gleason

(Address) 803 E Eastern Ave

15- ROBERT B KRAUTEL

Filed JUL 28 1920 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 27 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Colon

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry Ryan Wm A Foley M. D. (Coroner)

7/28, 1920. (Address) 711 E Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Carmel Cem.	July 28, 1920
20-UNDERTAKER	ADDRESS
Tilly & Feiler	403 S. Monroe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact residence of deceased is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

045185 D-48185

CERTIFICATE OF DEATH.

104-09

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 879 S. Second st. ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. J. Gummer.

(a) RESIDENCE. No. 879 S. Second ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 22 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER J. George Gummer.

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary K. Hartman

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant J. George Gummer.
(Address) 879 S. Second St.

15 Filed JUL 28 1920 ROBERT E. LEAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1920

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1920, to July 27, 1920, that I last saw her alive on July 26, 1920, and that death occurred, on the date stated above, at 7.15 a. m.

The CAUSE OF DEATH* was as follows:

Mes Colitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B Tilton, M. D.

, 19 (Address) 2921 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	July 29 1920

20 UNDERTAKER Lilly and Zeiler ADDRESS 4038 Belair Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

045186 HEALTH DEPARTMENT—CITY OF BALTIMORE 045186

CERTIFICATE OF DEATH. X 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 Hollins ST.: 18 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Canfield

(a) RESIDENCE. No. 1117 Hollins ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Wht	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George R Canfield

6 DATE OF BIRTH (month, day, and year) Nov 2, 1844

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bellville

(State or country) Canada

PARENTS

10 NAME OF FATHER Joseph Forrester

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Canada

12 MAIDEN NAME OF MOTHER Elizabeth Beninger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Canada

14 Informant Mrs Emma Canfield

(Address) 1117 Hollins St

15 Filed JUL 28 1920 ROBERT S. BRAUTEN Registrar

Burial Permit Oleth

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1920

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 19 20, to July 26, 1920, that I last saw h e alive on July 26, 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Arterio - Sclerosis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Henry Glassman, M. D.

(Address) 2627 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	July 29 1920

20 UNDERTAKER Joseph B Cook ADDRESS 1013 W. Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D45187 HEALTH DEPARTMENT—CITY OF BALTIMORE 152 D45187

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 N. Bentalou ST.; 20 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Farman Jr.

(Residence in Baltimore: No. 5 N. Bentalou St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 27 (Day), 1920 (Year)

7-AGE, ... yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or 15 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John J. Farman

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Jessie A. Bell

13-BIRTHPLACE OF MOTHER (State or Country), Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Farman

(Address) 5 N. Bentalou St.

15- Filed JUL 28 1920, 191... ROBERT B. KRAUTER Registrar. BURIAL Permit Oleta

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 27 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 27 1920, to ... 191..., that I saw h, m alive on July 27 1920, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Beer Bore (15 minute)

Asphyxiation

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) John K. Abercrombie M. D.

7/28, 1920 (Address) 1316 Eutaw Place

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, July 28, 1920

20-UNDERTAKER Wm J. Hartwell

ADDRESS 2236 W. Baltimore St.

CAUSE OF DEATH. Please answer all questions. Use ditto marks only when necessary. Be particular and write plainly. Do not abbreviate. Use black ink. Be sure to

Spec.—8-24-14—M. & T.—2000 Bks.

George Carter

045188

HEALTH DEPARTMENT—CITY OF BALTIMORE

045188

CERTIFICATE OF DEATH.

REGISTERED No. C 176

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 Hulcton Ave ST.; 27th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Carter

(Residence in Baltimore: No. 424 Hulcton Ave St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-~~SINGLE~~, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1843 (Year)

7-AGE, 77 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Local Preacher

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jefferson Walker

(Address) 424 Hulcton Ave Govans

15-

Filed JUL 28 1920 191 ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 28 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1/20 191, to July 26/20 191, that I saw him alive on July 26/20 191, and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows: Heloulin of Arm - Gotter

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Enlarged Prostate

(Duration) yrs. mos. ds.

(Signed) Geo H. Byerly M. D.

July 28, 1920 (Address) 5805 York Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Zion Cemetery, Govans — DATE OF BURIAL, Friday, 30., 1920

20-UNDERTAKER John A Bishop & Son — ADDRESS 1107 Druid Hill Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

045189 HEALTH DEPARTMENT—CITY OF BALTIMORE 045189

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4766 Park Heights ave ST.. 27 WARD)

REGISTERED NO. 1764

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Thomas Haughey

(a) RESIDENCE. No. 4766 Park Heights ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 22 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam Helper

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Reisterstown Balto Co Md

PARENTS

10 NAME OF FATHER Thomas K Haughey

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Del

12 MAIDEN NAME OF MOTHER Mary Devries

13 BIRTHPLACE OF MOTHER (city or town) Marrolsville (State or country) Carroll Co Md

14 Informant Miss Julia Haughey (Address) Reisterstown Md

15 Filed JUL 28 1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 19[illegible] to July 27, 1920 that I last saw h[illegible] alive on July 27, 1920 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis.

OVER

13 Months

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. H. Buckley, M. D.

(Address) 126 W. Belvedere ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashbury M. E. Cemetery	July 29 1920

20 UNDERTAKER Reisterstown Md ADDRESS Reisterstown Md

J. F. Elsink

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

142040 045190 X 40 045190

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 12 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Kenny

(a) RESIDENCE. NO. Johnsonburg Pa. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 da Hospital yrs. mos. 15 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Unkown

6 DATE OF BIRTH (month, day, and year) Unknown 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None HH

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Kenny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Welsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Hospital Record (Address) J. H. H.

15 Filed JUL 28 1920 ROBERT B. LATIMER Registrar of Vital Statistics

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1920

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1920, to July 27, 1920, that I last saw him alive on July 27, 1920, and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. X ds.

18 Where was disease contracted If not at place of death? At home

Did an operation precede death? Yes Date of July 15th

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Emile Holman, M. D.

7/27. 1920 (Address) J. N. Nov

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johnsonburg Pa	July 28 1920
20 UNDERTAKER Jack Lewis	ADDRESS 1411 E. Biddle St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45191 HEALTH DEPARTMENT—CITY OF BALTIMORE D45191

CERTIFICATE OF DEATH. X 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3004 Brighton ST.: 15 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Anna Freeman

(a) RESIDENCE. NO. 3064 Brighton ST., 15 WARD. (Newburg - Chas. Co. Md.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? 74 yrs. 10 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Francis Freeman

6 DATE OF BIRTH (month, day, and year) Sept-1-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Port Tobacco - Chas. Co. Maryland

PARENTS

10 NAME OF FATHER Stanislaus Farrall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co. Maryland

12 MAIDEN NAME OF MOTHER Catherine C. Stone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles Co. Maryland

14 Informant Mrs H. T. Tippett (daughter)

(Address) 3004 Brighton St

15 JUL 28 1920 Burial Permit Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

17

I HEREBY CERTIFY, That I attended deceased from May 20, 19.., to July 27, 19 20.

that I last saw h.. alive on July 27, 19 20.

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Chronic Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Kirby, M. D.

July 28 1920 (Address) 116 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Newport-Charles Co.-Md	July 29 1920

20 UNDERTAKER STEWART & MOWEN COMPANY (CHARLES F. TOOKER, Successor) ADDRESS 108 W. NORTH AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

045192 HEALTH DEPARTMENT—CITY OF BALTIMORE 045192

CERTIFICATE OF DEATH 108

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO. C

CITY OF BALTIMORE: (No. 213 N. Milton Ave St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clive D. Riddle + Guy D. Riddle

(Residence in Baltimore: No. 213 N. Milton Ave St.; 29 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. April 23, 1892 (Month) (Day) (Year)

7-AGE. 28 yrs. 3 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Wm H. Pugh

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Christina Eubank

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Guy D. Riddle

(Address) 213 N. Milton

15- Filed JUL 28 1920, 191 ROBERT E KRAUTER DEPUTY REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 28, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 23 1920, to July 28 1920, that I saw h a r alive on July 25 1920, and that death occurred, on the date stated above, at 6.55 A.M.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

Septicaemia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Ruptured Appendix (Pregnancy)

(Duration) yrs. mos. 4 ds.

(Signed) Louis A. Forbes M. D.

July 28, 1920 (Address) The Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oakland DATE OF BURIAL, July 30, 1920

20-UNDERTAKER Girkler & Girkler ADDRESS 1739 Eager

Directions for filling out this certificate are important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045193

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045193

CERTIFICATE OF DEATH.

118

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1541 E Madison ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nannie Brawner

(a) RESIDENCE. No. 1541 E Madison ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Franken

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work general domestic

(b) General nature of industry, business, or establishment in which employed (or employer) — 070

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Charles Co. Md.

PARENTS

10 NAME OF FATHER Henry Brawner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co. md

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Edith A. Johnson (Address) 1541 E Madison St

15 Filed JUL 28 1920 19 Burial Permit Issued Registrar ROBERT E LEE TYLER

CAUSE OF DEATH in plain terms, so that it may be properly classified. See reverse side of certificates. TION is very important. See instructions on back

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1920

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1920, to July 27, 1920, that I last saw her alive on July 26, 1920, and that death occurred, on the date stated above, at 7 p.m.

The CAUSE OF DEATH* was as follows:

Acute pancreatitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Intestinal Catarrh

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Balto. md

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. H. B. Robin M. D.

, 19 (Address) 153 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Popes creek. Charles. Co	July 29 1920

20 UNDERTAKER Milton Davis ADDRESS 413 N Eden ST

Spec.—6-9-19—H. P. Co.—1000 Bks.

2045194 HEALTH DEPARTMENT—CITY OF BALTIMORE 2045194

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2626 E. Balto ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gonzaga C. Hogg

(a) RESIDENCE. No. 2626 E. Balto ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Chas Hogg

6 DATE OF BIRTH (month, day, and year) Mar. 14-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Edward A. Healy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Jos. M. Smith (Address) 2626 E. Balto St.

15 JUL 28 1920 ROBERT E. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28th 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to July 28, 1920, that I last saw her alive on July 28, 1920, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes (Laboratory)

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

(Address) 2 E Read

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	7/31 1920
20 UNDERTAKER	ADDRESS
Chas. J. Evans & Son	118 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045195- HEALTH DEPARTMENT—CITY OF BALTIMORE 1045195-

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie L. Byrne

(a) RESIDENCE. No. 1706 N. Broadway ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 9 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds. (If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT NATURE OF OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married -

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) ~~WIFE~~ of Charles H Byrne -

6 DATE OF BIRTH (month, day, and year) March 24-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	0	4	3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md -

PARENTS

10 NAME OF FATHER Robert Montgomery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Catherine Clabby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland -

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md -

15 Filed JUL 28 1920 ROBERT P. BRAUTIGAM Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1920

17 I HEREBY CERTIFY, That I attended deceased from July 21st 1920, to July 27 1920, that I last saw h alive on July 27 1920, and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Uremic Coma - Chr. Nephritis -
(Not known - only under Observation 7 days -) (duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) Melancholia - obs (duration) 0 yrs. 0 mos. 21 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Urinalysis & Microscope

(Signed) Frank J Flannery, M. D.

. 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	7/30 1920
20 UNDERTAKER	ADDRESS
Chas. F. Evans & Son	118 W. Mt. Royal Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45196 HEALTH DEPARTMENT—CITY OF BALTIMORE D45196

CERTIFICATE OF DEATH. 842

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Anna Schilling

(a) RESIDENCE. NO. 1745 Hilton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1880 May 7

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
37 40	2	20		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER John Debler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Flint

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed JUL 29 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1920, to July 27, 1920, that I last saw her alive on July 26, 1920, and that death occurred, on the date stated above, at 2:00 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia & Cachexia

(duration) yrs. 3. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Holden, M. D.

7/27/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	7/29 19
20 UNDERTAKER	ADDRESS
Geo A Farley	Fulton & Fayette

CAUSE OF DEATH to be plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D45197 HEALTH DEPARTMENT—CITY OF BALTIMORE 5175 001 D45197

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 308 n Eden. St. 5 WARD)

REGISTERED NO. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julian Jones.

(Residence in Baltimore: No. 308 n Eden. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Mal

4-COLOR OR RACE: Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Sing

6-DATE OF BIRTH, July (Month) 26 (Day) 1918 (Year)

7-AGE, 5 yrs. mos. ds. If LESS than 1 day, hrs. or min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). born in Baltimore

PARENTS.

10-NAME OF FATHER. Lonnell Jones

11-BIRTHPLACE OF FATHER (State or Country). born in Baltimore

12-MAIDEN NAME OF MOTHER. Rachell Butler

13-BIRTHPLACE OF MOTHER (State or Country). born in Balt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lonnell Jones

(Address) 308 N Eden St

15-

Filed JUL 29 1920 G. H. Gross Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 26 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism Loss

by acute (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Kent Pauley M. D.

(Coroner)

7-28, 1920 (Address) 2 E. Ider

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Arlington Cemetery

DATE OF BURIAL, July 29, 1920

20-UNDERTAKER Mrs R A Elliott

ADDRESS 175 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45198 D45198

CERTIFICATE OF DEATH.

5 REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 N. Central ave ST.; ..... WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Zelda Edwards

(Residence in Baltimore: No. 508 N. Central ave. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH, July (Month) 6 (Day), 1908 (Year)

7-AGE, 12 yrs. — mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Nil 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), born in Baltimore Balto, Md.

PARENTS.

10-NAME OF FATHER, Stephen Edwards

11-BIRTHPLACE OF FATHER (State or Country), Balto, Md.

12-MAIDEN NAME OF MOTHER, Lyda Rigdon

13-BIRTHPLACE OF MOTHER (State or Country), Balto, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stephen Edwards

(Address) 508 N. Central ave.

15-

Filed ....., 191... JUL 29 1920 G. H. Gross Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 27 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 7/27/20, to 7/27/20, that I saw h[illegible] alive on 7/27/20, and that death occurred, on the date stated above, at 7:10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

about 3

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ... yrs. ... mos. ... ds.

(Signed) Ellen Field Boyle M. D.

7/28/20, 1920 (Address) 727 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Ashley Lawn	July 30, 1920
20-UNDERTAKER Wm H A Elliott	ADDRESS 1725 Ashland Ave

CAUTION—Be careful to fill in every item. All are important. See instructions on back of certificate.

D 45199

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924 D 45199

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 309 N. Forrest ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard L. Morton Sr.

(Residence in Baltimore: No. 309 Forrest St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Wid

6-DATE OF BIRTH, Unknown (Month) (Day), 1854 (Year)

7-AGE, 66 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sold produce
(b) General nature of industry, business, or establishment in which employed (or employer): in Market

9-BIRTHPLACE, (State or Country), Born in Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. L. Morton Jr.

(Address) 309 Forest

15-

Filed JUL 29 1924, 191.. H. H. Cross Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 27, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

Tail Race (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Dropsy (Duration) yrs. mos. ds.

(Signed) W. A. Riley M. D. (Coroner.)

July 28, 1924 (Address) 605 E. Fay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, July 29 1924

20-UNDERTAKER Wm R. A. Elliott

ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D45200

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45200

CERTIFICATE OF DEATH.

1752

PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin St. Hosp. ST. 4 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hyman Gamerman

(Residence in Baltimore: No. 113 N. Pine St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown (Month) (Day), 1913 (Year)

7-AGE, 7 yrs. mos. ds.

If LESS than 1 day, hrs. or min.? 100

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER, Abe Gamerman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rose Silberman

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Gamerman

(Address) 113 N Pine st

15-

Filed JUL 29 1920, 191 G. H. Case Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 27 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) and that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull &
Crush of Chest
Auto Accident

(Duration) yrs. mos. 3 hrs

CONTRIBUTORY (Secondary) Internal Hemorrhage

(Duration) yrs. mos. 3h ds.

(Signed) James M. Hanlon M. D. (Coroner.)

July 28th 1920 (Address) 700 E. Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death [illegible] SE Hosp In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

1504 Fayette St

Former or usual residence 113 N Pine St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale

DATE OF BURIAL, July 29 1920

20-UNDERTAKER Max Linson

ADDRESS 1127 E Balto. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 45201

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6 V 64 D 45201

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 N. Dallas ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rainey

(a) RESIDENCE. NO. 413 N. Dallas ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Rainey

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Ignatius Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Bradford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ran Adams
(Address) 413 N. Dallas St.

15 Filed JUL 29 1920 19.. G. H. Cree Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1920, to July 27, 1920, that I last saw h.. alive on July 27, 1920, and that death occurred, on the date stated above, at 2-20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

7-28. 1920 (Address) 120½ Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	July 30 1920
20 UNDERTAKER	ADDRESS 720
Mrs Rvet a dewitt	Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be a check of certificates.
TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045202

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045202

CERTIFICATE OF DEATH.

104

5

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1245 St. Matthews ST.; WARD)

2-FULL NAME Carroll L. Gaylands

(a) RESIDENCE. No. 1245 St. Matthews ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 1/1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) md

PARENTS

10 NAME OF FATHER Carroll Gaylands

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) md

12 MAIDEN NAME OF MOTHER Lillian Schilling

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) md

14 Informant Mrs Gaylands
(Address) 1246 St Matthews Dr

15 Filed JUL 29 1920 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

CAUSE OF DEATH to be plainly written in ink, so that it may be legible. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1920

17

I HEREBY CERTIFY, That I attended deceased from July 1 1920 to July 28 1920, that I last saw him alive on July 27 1920 and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Cardiac Collapse

(duration) yrs. ..... mos. 27 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? ~~Gl. Path. Cyrus~~

What test confirmed diagnosis? Clin. & early symp.

(Signed) G. G. Klunk M. D.

, 19 (Address) 1301 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. Co.	July 29 1920
20 UNDERTAKER	ADDRESS
McGinnis-Carroll	4209 Redmond Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45203 HEALTH DEPARTMENT—CITY OF BALTIMORE D45203

150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 S. Wolfe St.: 2 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Zebro

(a) RESIDENCE. No. 405 S Wolfe St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15/20.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore. Md.

PARENTS

10 NAME OF FATHER Wladislaus Zebro.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER Katharine Szusko

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Wladislaus Zebro

(Address) 405 S. Wolfe St

15 Filed JUL 29 1920 ROBERT B. CRAWFORD Registrar

Burial Permit Oleft

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1920

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1920, to July 29, 1920.

that I last saw h[illegible] alive on July 29, 1920.

and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Trouble.

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William P. Grant M. D.

July 29 1920 (Address) 801 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	July 29 1920
20 UNDERTAKER	ADDRESS
W F Sadowski.	705 S. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Certificate may be prosecuted if TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45204

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 45204

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2324 Essex ST.: 1 - WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME LOUIS E. BANASZKIEWICZ,

(a) RESIDENCE. No. 2324 Essex ST., I - WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male,	White,	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 3-1920.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child, 500

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.,

PARENTS

10 NAME OF FATHER Louis Banaszkiewicz,

11 BIRTHPLACE OF FATHER (city or town) Baltimore,
(State or country) Md.,

12 MAIDEN NAME OF MOTHER Stella Szopczynska,

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Md.,

14 Informant Louis Banaszkiewicz, (Father)
(Address) 2324 Essex Street

15 Filed JUL 29 1920 19 ROBERT E. [illegible]
Registrar
Burial Permit Oleb

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUL 28 1920 19

17 I HEREBY CERTIFY, That I attended deceased from July 25, 19 20, to July 28, 19 20, that I last saw h[illegible] alive on July 28, 19 20, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. Wachsman M. D.

July 28. 1920 (Address) 16 S Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	July 30 " 1920
20 UNDERTAKER	ADDRESS
M. F. Sadowski.	705 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Omissions will delay registration of certificates. Please write plainly. Use black ink. Do not use lead pencil. Do not abbreviate. Answer every question. If none, write none. If unknown, state unknown. Do not leave any blanks. Do not write across the face of certificate. Do not fold certificate. Do not write in margin. Do not write on back of certificate. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D-45205

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-45205

CERTIFICATE OF DEATH.

REGISTERED NO. C-40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3016 Baker ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Timothy Naughton

(Residence in Baltimore: No. 3016 Baker St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word.) Married

6-DATE OF BIRTH, Aug. (Month) 15 (Day) 1866 (Year)

7-AGE, 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) Helper

9-BIRTHPLACE, (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER, Bart. Naughton

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Mary Conody

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bart Naughton

(Address) 3016 Baker St.

15- Filed JUL 29 1920, 191.. ROBERT B KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 27 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1920, to July 27 1920, that I saw h[illegible] alive on July 27 1920, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma - Stomach & Liver.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 6 yrs. mos. 7 ds.

(Signed) Edward McCandlish M. D.

July 28, 191.. (Address) 1st Hollins St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, July 30, 1920

20-UNDERTAKER H. C. Brannigan Son

ADDRESS 317 N. Edmondson Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~D 4.5206~~ 104 D 45206

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1203 Argyle ave ST.; 17 WARD)

2-FULL NAME Harry V. Watkins

(a) RESIDENCE. No. 1203 Argyle ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of /

6 DATE OF BIRTH (month, day, and year) Nov 25 / 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) City Balto
(State or country)

PARENTS

10 NAME OF FATHER Wm G. C. Watkins

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Hattie Collis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Wm G. C. Watkins
(Address) 1203 Argyle ave

15 Filed JUL 29 1920 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1920

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1920, to July 28, 1920, that I last saw him alive on July 27, 1920, and that death occurred, on the date stated above, at 10 AM

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr V. Fitzgerald M. D.

7/29, 1920 (Address) 1118 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt O Auburn Cem	July 29 '20
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Hanover St

mation should be carefully supplied. Exact statement of ... may be properly classified. Exact statement of ... CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back ... back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45207 D45207

CERTIFICATE OF DEATH.

81

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1931 N. Gay ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman F. Zemke.

(Residence in Baltimore: No. 1931 N. Gay St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept 1, 1839 (Month) (Day) (Year)

7-AGE, 80 yrs. 10 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Watchman
(b) General nature of industry, business, or establishment in which employed (or employer)..... D&V

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, — Zemke

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Christine Zemke

(Address) 1931 Biddle Road

15- JUL 29 1920 ROBERT E KRAUTER 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 27, 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1920, to July 26 1920, that I saw him alive on July 26 1920, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Senelity

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) B P Herzog M. D.

July 28, 1920 (Address) 130 N Patterson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, July 29, 1920

20-UNDERTAKER Robt J Turner Jnr — ADDRESS 1412 N. Broadway

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

045208

HEALTH DEPARTMENT—CITY OF BALTIMORE

045208

CERTIFICATE OF DEATH.

REGISTERED NO. 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 728 E 30th St.) (ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Goldstraw

(a) RESIDENCE. NO. 728 E 30th St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER William Goldstraw

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Clara Larkin

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant H M Freeman
(Address) 2631 Calvert St

JUL 29 1920 ROBERT B. BEAUTEN Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1920

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1920, to July 28, 1920, that I last saw her alive on July 28, 1920 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus Caeruleus (duration) yrs. 15 mos. days.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 728 E 30th St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Signs.

(Signed) H M Freeman, M. D.

, 19 (Address) 2631 Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	July 29th 1920
20 UNDERTAKER George Schilling & Sons	ADDRESS 1116 E Monument St

BEFORE SIGNING, READ CAREFULLY. Every statement must be true to the best of your knowledge and belief. Every question must be answered or the reason for failure to answer stated. Unless the cause of death can be certified to by a physician, the coroner must be notified. Do not report indefinite causes of death, such as heart failure, exhaustion, etc., but give the disease causing such condition. Causes of death which may be the result of either natural disease or violence must be fully explained. Write plainly with pen and ink and use only standard abbreviations. Do not use ditto marks. Sign and return certificate promptly. Any person who knowingly makes a false statement in this certificate is guilty of a misdemeanor and subject to fine or imprisonment. CAUSE OF DEATH in plain terms, so that it may be properly classified. Last statement of cause of death may be corrected by supplemental certificate. See instructions on back of certificates. ATTENTION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

045209 HEALTH DEPARTMENT—CITY OF BALTIMORE 045209

CERTIFICATE OF DEATH. X 91

1-PLACE OF DEATH REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Institute of Our Lady of the Blessed Sacrament 3800 Garrison Ave ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lawrence McClellan

(Residence in Baltimore: No. 1013 Sassafras Ct St.; ....yrs., 6 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, March 26, 1919
(Month) (Day) (Year)

7-AGE, 1 yrs. 4 mos. 2 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Philadelphia Pa.

PARENTS.

10-NAME OF FATHER, Lawrence McClellan

11-BIRTHPLACE OF FATHER (State or Country), Detroit

12-MAIDEN NAME OF MOTHER Alice Madkins

13-BIRTHPLACE OF MOTHER (State or Country), Cambridge Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Mc Clellan

(Address) 1013 Sassafras Court

15- Filed JUL 29 1920 ROBERT E. KRAUTER Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 28, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 26 1920, to July 28 1920, that I saw her alive on July 27 1920, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ....yrs. ....mos. 4 ds.

(Signed) W. S. Hibbett M. D.

July 29, 1920 (Address) 3402 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross Cemetery Md	July 29 1920
20-UNDERTAKER John F Denny	ADDRESS 715 Light St

CAUSE OF DEATH important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45210 HEALTH DEPARTMENT—CITY OF BALTIMORE D45210

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Poplar and Hickory ST.: Overlea 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E Bennett

(a) RESIDENCE. No. Poplar Ave & Hickory ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Bennett

6 DATE OF BIRTH (month, day, and year) May 18 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	2	9	

086

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Carver

(b) General nature of industry, business, or establishment in which employed (or employer) Piano Industry

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Andrew Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Faud

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ella Bennett (Address) Poplar Ave & Hickory St

15 Filed JUL 28 1920 ECBERT E KRAUTER Registrar Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/27 1920

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1920, to July 27, 1920, that I last saw h[illegible] alive on July 27, 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pulmonal Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gustave A Fritz, M. D.

, 19 (Address) Overlea

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL JUL 30 1920

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45211 HEALTH DEPARTMENT--CITY OF BALTIMORE D45211

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 720 St. Peter St. 21 WARD)

2-FULL NAME John M. Corpthwaite

(a) RESIDENCE. NO. 720 St. Peter ST., ...WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 29 - 1849

7 AGE: Years 71 | Months 2 | Days | If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist — 031

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Bartlett-Hayward Co

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Robert H. Corathwaite

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Martha Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs. Ella Lefmer
(Address) 720 St. Peter St.

15 Filed JUL 29 1920 ROBERT B. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1920

17 I HEREBY CERTIFY, That I attended deceased from March 4. 1919. to July 28. 1920.
that I last saw h-im alive on July 20. 1920.
and that death occurred, on the date stated above, at 9 a m.
The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 6 yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stethescope Urinary Exam

(Signed) J E. Muse M. D.

, 19 (Address) 1520 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. | DATE OF BURIAL: July 31 1920.

20 UNDERTAKER: John Edward Lee | ADDRESS: 908 Walbert Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE STATEMENTS AND OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45212 D45212

CERTIFICATE OF DEATH.

REGISTERED NO. 6 19

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1517 Mulliken ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Cassell

(a) RESIDENCE. NO. 1517 Mulliken ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs mos. ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Cassell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant James Thomas
(Address) 1517 Mulliken st

15 Filed JUL 29 1920 ROBERT E KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1920

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1920, to July 27, 1920, that I last saw him alive on July 27, 1920, and that death occurred, on the date stated above, at 10 9' m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Balto - Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J W C Robinson M. D.

(Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	July 30 1920

20 UNDERTAKER John W Henderson ADDRESS 1502 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement must be complete. See instructions on back of certificates.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45213 HEALTH DEPARTMENT—CITY OF BALTIMORE D45213

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH Johns Hopkins Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 25 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Finkbeimer

(a) RESIDENCE. No. 227 Patapsco St. Westport Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Aug. ? 1919

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11½		

8 OCCUPATION OF DECEASED 000

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Charles Finkbeimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER May Logan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Hospital record (Address) J. H. H.

15 Filed JUL 29 1920 19 [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1920

17 I HEREBY CERTIFY, That I attended deceased from July 25 1920, to July 28 1920, that I last saw him alive on July 28 1920, and that death occurred, on the date stated above, at 12 00 [illegible] m.

The CAUSE OF DEATH* was as follows: ~~acute~~ Diarrhoea

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Patient's home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) J.H.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bradford P. S. P. Co.	July 30th 1920

20 UNDERTAKER Knell & Son ADDRESS 1729 W Pratt

CAUSE OF DEATH should be plainly written. Use ink. Do not use pencil. Do not write on back of certificates. Every question must be answered. If unknown, say so. Do not leave blanks. Write plainly. Use figures for dates. Be sure to answer correctly EVERY QUESTION. Read carefully the instructions on back of certificate. Your CAREFUL ATTENTION is very important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

0945214

HEALTH DEPARTMENT—CITY OF BALTIMORE

0945214

CERTIFICATE OF DEATH.

40

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 128 Mc Phail ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christian E. Gysner

(Residence in Baltimore: No. 128 Mc Phail St.; about 45 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Nov. (Month) 11 (Day), 1855 (Year)

7-AGE, 64 yrs. 8 mos. 16 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Butcher
(b) General nature of industry, business, or establishment in which employed (or employer): 013

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Gottlieb Gysner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Katharina Schaut

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Gysner

(Address) 128 Mc Phail St.

15-

Filed ..... 191 ..... ROBERT J. LITTLE Registrar.

JUL 29 1920

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 27 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 9 1920 to July 27 1920, that I saw him alive on July 27 1920, and that death occurred, on the date stated above, at 8 40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall Bladder & Liver

(Duration) Over 5 mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Henry C. Coble M. D.

July 27, 1920. (Address) 1203 N. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, July 30., 1920

20-UNDERTAKER Knell & Son

ADDRESS 912 W Pratt st

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L045215 HEALTH DEPARTMENT—CITY OF BALTIMORE L045215

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1330 N Mount, St.: 15 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ollie Christian

(a) RESIDENCE. No. 1330 N. Mount St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant, 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edward Christian

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Lula Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Edward Christian
(Address) 1330 N. Mount St.

15 Filed JUL 29 1920 ROBERT D. KAULTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1920

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1920, to July 27, 1920, that I last saw him alive on July 27, 1920, and that death occurred, on the date stated above, at 9, P, m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes;

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H Wright, M. D.

July 27 1920 (Address) 1209 Preston ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: July 30 1920

20 UNDERTAKER: Edw. Ruggold — ADDRESS: 1463 Carey St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L45216 — 45 L 2045216

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1432 Presstman St.; 15 Ward)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josefa Sisco

(Residence in Baltimore: No. 1432 Presstman St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 56 yrs. t mos. t ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country) Calvert County, Maryland.

PARENTS.

10-NAME OF FATHER, Daniel Sisco

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Sisco

(Address) 1532 Presstman St

15- Filed JUL 29 1920 191... ROBERT B. LEAUTER Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 27 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1918, to July 27 1920, that I saw him alive on July 26 1920, and that death occurred, on the date stated above, at 7 0 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Urethra

(Duration) 1 yrs. 6 mos. t ds.

CONTRIBUTORY (Secondary) Metastasis to Brain and glands

(Duration) t yrs. 8 mos. t ds.

(Signed) Charles E. Clark M. D.

July 28, 1920 (Address) 1306 N. Gilmor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Zion

DATE OF BURIAL, July 31., 1920.

20-UNDERTAKER Edw. Ringgold

ADDRESS 1463 Carey St

CAUSE OF DEATH must be plainly written. Please answer all questions. Every certificate is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045217

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045217

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Fields

(a) RESIDENCE. No. 915 Kiddle Court. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 44 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Raleigh, North Carolina

PARENTS

10 NAME OF FATHER Francis Tillett

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

7/26/20

14 Informant Hospital Records.

(Address) New City Hospital

15 JUL 29 1920 ROBERT B KRAMER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1920, to July 26, 1920

that I last saw her alive on July 26, 1920

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis without cerebral hemorrhage 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) W. H. Hoffman, M. D.

(Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 29 1920

20 UNDERTAKER Edw. Ringgold ADDRESS 1463 N. Carey St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MODE OF DYING is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45218 HEALTH DEPARTMENT—CITY OF BALTIMORE D45218

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes' Hospital (25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Mitten

(a) RESIDENCE. NO. N Agnes Hosp. ST., WARD. Westminster

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. da.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24-20

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	Infant		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of Industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Claude Mitten

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER M. Boyland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. Claude Mitten

(Address) 95 E. Maine St

15 Filed JUL 29 1920 Westminster Md

ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29 1920

17

I HEREBY CERTIFY, That I attended deceased from 7-24, 1920, to 7-29, 1920

that I last saw h~~e~~ alive on 7-29, 1920

and that death occurred, on the date stated above, at 10:20 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth

6 days.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cold & not Assimilated Food (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. E. Nicholas, M. D.

. 19 (Address) 704 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster St John

DATE OF BURIAL 7/29 1920

20 UNDERTAKER H Bankard & Son

ADDRESS Westminster Md

Spec.—6-9-19—H. P. Co.—1000 Bks.

14/2317 1045219

HEALTH DEPARTMENT—CITY OF BALTIMORE 1045219

CERTIFICATE OF DEATH.

5 — 14

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp ST.; (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sebastian Flowers

(a) RESIDENCE. No. 523 N. Eden St ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): May 28-1919

7 AGE: 1 Years 2 Months Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child 20

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Sebastian Flowers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Portugal

12 MAIDEN NAME OF MOTHER: Jessie Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Hospital Record J. H. H.
(Address)

15 Filed JUL 29 1920 ROBERT P. LAMDEN Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 1920

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1920, to July 28, 1920, that I last saw h[illegible] alive on July 28, 1920, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Patients home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stool culture +

(Signed) Wm Happ, M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	[illegible]
20 UNDERTAKER: Ehlf B Pyle	ADDRESS: 102 E Mount

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. Every statement must be complete. Every blank must be filled. Use ditto marks only when they will not change the meaning. Do not write on back of certificates. TION is very important. See instructions on back of certificates.

Lucius Bradley.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45220 HEALTH DEPARTMENT—CITY OF BALTIMORE D45220

1032

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 650 Redwood ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucius Bradley

(a) RESIDENCE. No. 650 Redwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Jesse Steal Co.

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Jerry Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Mandy Lyett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Mary Bradley (Address) 652 Redwood St.

15 Filed JUL 29 1920 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-27— 1920

17 I HEREBY CERTIFY, That I attended deceased from April 16th, 1920, to July 27th, 1920, that I last saw him alive on July 26th, 1920, and that death occurred, on the date stated above, at 1:15 P.M.

The CAUSE OF DEATH* was as follows:

Uremic Gastritis

(duration) yrs. 3 mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jas E Cayson, M. D.

7-27-1920 (Address) 1003 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Maxton N. C.	July 30 1920
20 UNDERTAKER	ADDRESS
Harry A. Woodcock	1726 Orleans St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45221

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45221

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 W. Lee ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Broening

(a) RESIDENCE. No. 16 W. Lee ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Kyne Broening

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
~~75~~	75	5		

8 OCCUPATION OF DECEASED 036

(a) Trade, profession or particular kind of work Horse shoer

(b) General nature of industry, business, or establishment in which employed (or employer) employer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry J Broening

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary L. Broening
(Address) 16 W Lee St

15 Filed JUL 29 1920 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/27/20 19

17 I HEREBY CERTIFY, That I attended deceased from April 10/20 19.... to July 27/20 19....
that I last saw h.. alive on July 27 19 20.
and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Myxosarcoma of Parotid

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Jas A O'Donnell M. D.

7/27 19 (Address) 107 E West St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL July 30 1920

20 UNDERTAKER M. H. Flynn

ADDRESS 1422 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

N 45222 HEALTH DEPARTMENT—CITY OF BALTIMORE N 45222

CERTIFICATE OF DEATH. 104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 638 N Gilmor ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Clark Morton Gilbert

(a) RESIDENCE. No. 638 N Gilmor ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. 3 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 5 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Alexander C. Gilbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Salisbury Maryland

12 MAIDEN NAME OF MOTHER Katherine L. Morton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Katherine L. Gilbert
(Address) 638 N Gilmor

15 Filed JUL 29 1920 ROBERT [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1920

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1920, to July 28, 1920, that I last saw him alive on July 28, 1920, and that death occurred, on the date stated above, at 8 10 a. m.

The CAUSE OF DEATH* was as follows:

0532

Meningitis.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Otitis Media.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M Brennan Hood, M. D.

7/29, 1920 (Address) 626 N Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 30 1920
20 UNDERTAKER	ADDRESS
H. J. Richardson & Son	Norman

CAUSE OF DEATH must be plainly written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45223

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45223

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 Hanover ST.: 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carroll W. Cork

(a) RESIDENCE. No. 817 Hanover ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1-1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Charles W. Cork

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Priscilla Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Priscilla Cork

(Address) 817 S. Hanover St

15 Filed JUL 29 1920 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1920

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1920, to July 28, 1920, that I last saw h~~e~~ alive on July 28, 1920, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. E. K. Campbell M. D.

July 28 1920 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	July 31 1920

20 UNDERTAKER — ADDRESS

F. H. Krause & Son — 703 Hanover

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 45224 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45224

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 27 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Beneze

(a) RESIDENCE. NO. 519 Oakland Ave ST. Gorans WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
m.	white	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Elizabeth J Beneze

6 DATE OF BIRTH (month, day, and year) June 22/1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) 029

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas Beneze

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER A. Hoffmeister

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth J Beneze

(Address) 519 Oakland Ave Towson

15 FILED JUL 30 1920 ROBERT T. KELLER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1920

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1920, to July 29, 1920, that I last saw him alive on July 29, 1920, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mesenteric thrombosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 29-1920

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J M Hundley Jr M. D.

, 19 (Address) University Hospital Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 31 1920
20 UNDERTAKER	ADDRESS
H M Cook	N. G Md.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45225 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45225

CERTIFICATE OF DEATH. 1045

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 517 E 28th St. ; ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Freeman Pearsin.

(a) RESIDENCE. NO. 517 E 28th St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 4/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 18 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward Pearsin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Havre de Grace Md.

12 MAIDEN NAME OF MOTHER Ruby Manning

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Havre de Grace Md.

14 Informant Ernest Pearsin

(Address) 517 E 25th St.

15 Filed JUL 30 1920 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28th 1920

17

I HEREBY CERTIFY That I attended deceased from July 19th 1920 to July 28th 1920

that I last saw him alive on July 28th 1920

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Diet.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) G. O'Hara Gatchell M. D.

, 19 (Address) 401 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Havre de Grace	July 30 1920
20 UNDERTAKER Wm Cook	ADDRESS H de G Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45226

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45226

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 N. Edm ST.: 10 WARD)

REGISTERED NO. 170

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony J. Soellers

(a) RESIDENCE. No. 1218 N. Edm ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER August Soellers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Zrigler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Carrie Gilbert
(Address) 1218 N. Edm St.

15 JUL 30 1920 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1920

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1920, to July 27, 1920.
that I last saw him alive on July 27, 1920.
and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of the Lungs
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam. of urine

(Signed) Robt J. Green, M. D.

7-24-1920 (Address) 120½ Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 31 1920
20 UNDERTAKER	ADDRESS
Frank A. Fink	915 S. Gay St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D45227 HEALTH DEPARTMENT—CITY OF BALTIMORE D45227

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 618 E. Washington St.; 2 WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie McElwee

(Residence in Baltimore: No. 618 E. Washington St.; yrs., 5th mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. Sept 10, 1837 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
65 yrs. 10 mos. 13 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Wm Arden

11-BIRTHPLACE OF FATHER (State or Country). France

12-MAIDEN NAME OF MOTHER Ann Kinn

13-BIRTHPLACE OF MOTHER (State or Country). " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm F. Kamphaus

(Address) 267 E. Edmondson

Filed JUL 30 1920, 191.... ROBERT P. PRAUTER Registrar of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 25, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Harry Firth Ewell M. D. (Coroner)

July 29, 1920 (Address) 1610 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, July 30 1920

20-UNDERTAKER Wm Cook

ADDRESS W. & M.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

045228 HEALTH DEPARTMENT--CITY OF BALTIMORE 045228

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C 5243

CITY OF BALTIMORE (No. 807 States ST.: 3 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Dambrauskas Bruno

(Residence in Baltimore: No. 807 States St.: 14 yrs. mos. ds.)

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: [illegible], 1 (Month) (Day) (Year)

7-AGE: 21 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 837

9-BIRTHPLACE (State or country): Italy

PARENTS

10-NAME OF FATHER: Frank Dambrauskas

11-BIRTHPLACE OF FATHER (State or country): Italy

12-MAIDEN NAME OF MOTHER: Anna Debola

13-BIRTHPLACE OF MOTHER (State or country): Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Dambrauskas
(Address) 807 States St

15-
Filed JUL 30 1920 191 ROBERT E. LEE REGISTRAR
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: July 28 (Month) (Day), 1920 (Year)

17-I HEREBY CERTIFY, That I attended deceased from July, 1919, to July 25 1920, that I saw h[illegible] alive on July 28, 1920, and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Henry Sypan [illegible] M. D.
July 29, 1920 (Address) 1616 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Timothy Cemetery — DATE OF BURIAL: July 30, 1920

20-UNDERTAKER: Randall Apgar & Son — ADDRESS: [illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045229 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045229

CERTIFICATE OF DEATH. 104V

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 S Durham ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Bobbitz

(a) RESIDENCE. No. 106 S. Durham ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 23 1920

7 AGE Years Months 2 Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Infant 600
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Ben Bobbitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto County Maryland

12 MAIDEN NAME OF MOTHER Edna V Connell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Ben Bobbitz
(Address) 106 S Durham

15 Filed . 19
JUL 30 1920 ROBERT P LAZZER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1920

17 I HEREBY CERTIFY, That I attended deceased from July 27 . 1920. to July 29 . 1920
that I last saw him alive on July 29 1920
and that death occurred, on the date stated above, at 11:45 P m.
The CAUSE OF DEATH* was as follows:

Acute Ulcerative Colo-Colitis
(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Acidosis
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) F Fred Ruzicka, M. D.

7-29. 1920 (Address) 800 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Remitz

DATE OF BURIAL July 30 1920

20 UNDERTAKER Wendell Appel & Son

ADDRESS 878 Lm

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Henry Schwan.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045230

1045230

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH Hebrew Aged Home for Infirmable REGISTERED NO.

CITY OF BALTIMORE: (No. 2102 E Baltimore St.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Schwan

(a) RESIDENCE. NO. 2102 E Balto St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 6 ds. How long in U. S., If of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1411 E Balto St

15 FILED JUL 30 1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1920

17 I HEREBY CERTIFY, That I attended deceased from July 25 1920, to July 29, 1920, that I last saw him alive on July 29, 1920, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia (Broncho)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D.

7/29/20 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	July 29 1920

20 UNDERTAKER ADDRESS

Jack Lewis, 1411 E. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D45231

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 D45231

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Little Sisters of the Poor REGISTERED No. C.....

CITY OF BALTIMORE: (No..... ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margarete Reilly

(Residence in Baltimore: No. Little Sisters of the Poor St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Wid.

6-DATE OF BIRTH, ... (Month) ..... (Day) 1850 (Year)

7-AGE, 70 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Hughs McDonnell

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Marg O'Connor

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15- Filed JUL 30 1920, 191.. ROBERT P. KLAUTER, Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 11 Cord 191.., to ..... 191....,
that I saw her alive on July 27 1920,
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Warner M. D.

July 29, 1920 (Address) 1133 Vaclay St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 15 yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Cathedral | DATE OF BURIAL, July 30, 1920

20-UNDERTAKER H. C. Windefeld | ADDRESS 914 Greenmt Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45232 HEALTH DEPARTMENT—CITY OF BALTIMORE D45232

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 E. Eager ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A Fitzpatrick

(a) RESIDENCE. No. 810 E. Eager ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 28 1859

7 AGE: Years 60 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Patrick H. Fitzpatrick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Fallon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Teresa A. Fitzpatrick (Address) 810 E. Eager St.

15 Filed JUL 30 1920 ROBERT E. REUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1920

17 I HEREBY CERTIFY, that I attended deceased from May 4, 1920, to July 29, 1920, that I last saw h.. alive on July 28, 1920, and that death occurred, on the date stated above, at 12.20 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 1 ? yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Dr Bloom & Wes. M. D.

7/31 1920 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Govans DATE OF BURIAL: July 31 1920

20 UNDERTAKER: H. C. Weckfeld ADDRESS: 914 Greenmt Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Rks.

D 45233 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45233.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 S. Gilmor St.; 19 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara A. Benderwitter

(Residence in Baltimore: No. 210 S. Gilmore St.; 76 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July 4th (Month) (Day) 1844 (Year)

7-AGE, 76 yrs. mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Jacob Jerge

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs D. Healey

(Address) 210 S Gilmore

15- Filed JUL 30 1920, 191.. ROBERT E. LEAUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 28 1920, to July 28 1920, that I saw h[illegible] alive on July 28 1920, and that death occurred, on the date stated above, at 5309 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) yrs. 7 mos. ds.

(Signed) Chas A Schaefer M. D.

July 29, 1920 (Address) 57 E. Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, July 31, 191..

20-UNDERTAKER John J. Fields 120 W. Fayette — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45234 D45234

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 344 S. Woodyear St.; 19 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Froeb

(Residence in Baltimore: No. 344 S. Woodyear St. St.; 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, August 20, 1862
(Month) (Day) (Year)

7-AGE. 57 yrs. 10 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): M. E. Church

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Froeb

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Susan Redberg

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. August Froeb

(Address) 344 S. Woodyear St

15- Filed JUL 30 1920 ROBERT I KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 28, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 13 1920, to July 28 1920, that I saw h[illegible] alive on July 28 1920, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of the Intestines

Probably (Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. L. McKolay M. D.

July 29, 1920 (Address) 130 S. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, July 31, 1920

20-UNDERTAKER John J. Fulda — ADDRESS 1200 W Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

145235 HEALTH DEPARTMENT—CITY OF BALTIMORE 145235

CERTIFICATE OF DEATH.

15-80

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. #2221 Roslyn Ave. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Walker Chandlee.

(a) RESIDENCE. No. #2221 Roslyn Ave. ST., 15 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 56 yrs. 3 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Chandlee.

6 DATE OF BIRTH (month, day, and year) April-17-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	3	11	

8 OCCUPATION OF DEECASED 045

(a) Trade, profession or particular kind of work Pres. H.P. Chandlee Sons.

(b) General nature of industry, business, or establishment in which employed (or employer) Wholesale China.

(c) Name of employer H.P. Chandlee Sons Co.

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Henry P. Chandlee

11 BIRTHPLACE OF FATHER (city or town) Zion (State or country) Cecil Co., Maryland.

12 MAIDEN NAME OF MOTHER Catherine Gaw.

13 BIRTHPLACE OF MOTHER (city or town) Ellicott City (State or country) Howard Co., Maryland.

14 Informant Mr. Geo. M. Chandlee, (son) (Address) #2221 Roslyn Ave.

15 Filed JUL 30 1920 ROBERT E. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28th 1920

17 I HEREBY CERTIFY, That I attended deceased from July 28— , 1920, to July 28th , 1920, that I last saw h alive on July 28th , 1920, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Acute Sclerosis —

(duration) May yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Angina Pectoris — (duration) 1 yrs. — mos. — ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs &c. &c.,

(Signed) Harry Clarke, M. D.

, 19 (Address) 132 Park Ave —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July/30/1920
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45236

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45236

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital St.: 76 91 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Hickman

(a) RESIDENCE. No. Unknown St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Laurence Hickman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ~~Unknown~~ Baltimore Md

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed JUL 30 1920 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1920

17 I HEREBY CERTIFY, That I attended deceased from February 2, 1920, to July 28, 1920, that I last saw him alive on July 27, 1920, and that death occurred, on the date stated above, at 9:15 A. m.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No especial test.

(Signed) B. Hickman, M. D.

7-28-20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 30th 1920
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D45237

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45237

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 1514 Linden Av. St.; 11 Ward)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Victor H Bruns

(Residence in Baltimore: No. 832 N. Howard St. St.; 60 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH May (Month) 11 (Day), 1851 (Year)

7-AGE, 69 yrs. 2 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Poor
(b) General nature of industry, business, or establishment in which employed (or employer) none

9-BIRTHPLACE, (State or Country), Frederick Maryland.

PARENTS.

10-NAME OF FATHER, Francis Bruns

11-BIRTHPLACE OF FATHER (State or Country), Francis Gambert

12-MAIDEN NAME OF MOTHER Frances

13-BIRTHPLACE OF MOTHER (State or Country), France.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Hughson

(Address) 1514 Linden Av

15-

Filed JUL 30 1920 ROBERT I. FISHER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 28th (Day), 1920 (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 17 1920 to July 27 1920, that I saw him alive on July 28th 1920, and that death occurred, on the date stated above, at 7.14 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

Primary

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma of Rectum

(Duration) ..... yrs. 5 mos. ..... ds.

(Signed) Walter Hughson M. D.

7-27, 1920. (Address) 1514 Linden Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 14 ds. In the State 60 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? ✓

Former or usual residence 832 N Howard St

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	7/31, 1920

20-UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D45238 HEALTH DEPARTMENT—CITY OF BALTIMORE D45238

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 175

CITY OF BALTIMORE (No. Hospital St. WARD)

2-FULL NAME Theodore Schmidt Schmitz

(Residence in Baltimore: No. 2338 Monument St.; 14 yrs. 11 mos. 17 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Boy

6-DATE OF BIRTH, (Month) Aug (Day) 11th, (Year) 1905

7-AGE, 14 yrs. 11 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): City

PARENTS.

10-NAME OF FATHER: Fred C. Schmidt

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Ella L. Wenman

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred Schmidt

(Address) 2338 E Monument

15- JUL 30 1920, 191... ROBERT P. LEAUTHER Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: (Month) Jany (Day) 28, (Year) 1920

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) Jany thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Coroner find (but said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows: Pneumonia Lobar Lung Acute

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) J K Bowles M. D. Coroner

..., 191... (Address) 45 E. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: Oak Lawn — DATE OF BURIAL: July 31 1920

20-UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans

N. B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D45239 HEALTH DEPARTMENT—CITY OF BALTIMORE D45239

CERTIFICATE OF DEATH.

REGISTERED No. C 1049

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 801 South Bond St., 2nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME MARY BUCZKOWSKA,

(Residence in Baltimore: No. 801 South Bond St.) 1 yrs., mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female,	White,	Single.

6-DATE OF BIRTH, July 20 th- 1919
(Month) (Day) (Year)

7-AGE, 1 yrs. mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child,
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.,

PARENTS.

10-NAME OF FATHER, Wojcech Buczkowski,

11-BIRTHPLACE OF FATHER (State or Country), Poland,

12-MAIDEN NAME OF MOTHER Katharine Bidzyzonka,

13-BIRTHPLACE OF MOTHER (State or Country). Poland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katharine Buczkowska, (Mother)

(Address) 801 South Bond Street

15-

Filed JUL 30 1920 191.... ROBERT P. PRAETER
Registrar.
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest,
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cause Not Given

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Clement Ryan, M. D.
(Coroner)

July 29, 1920. (Address) Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary. DATE OF BURIAL, July 30, 1920

20-UNDERTAKER M. F. Sadowski ADDRESS 905 S. Ann

Spec. 6-9-19—H. P. Co.—1000 Bks.

1245240 HEALTH DEPARTMENT—CITY OF BALTIMORE 1245240

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 Division St ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Lockman

(a) RESIDENCE. No. 1217 Division St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benj Lockerman

6 DATE OF BIRTH (month, day, and year) Unknown 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bath Md

PARENTS

10 NAME OF FATHER Isaac Savage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Celia Dixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

11 Informant Alberta Phillips

(Address) 1217 Division

15 Filed JUL 30 1920 ROBERT A KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1920

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1920, to July 28, 1920, that I last saw h[er] alive on July 28, 1920, and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F Blandford M. D.

July 29 1920 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	July 30 1920

20 UNDERTAKER Jno W. Evans Son ADDRESS 1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45241

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1042 D45241

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 34 S. 2nd ST.; Brooklyn WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence St. Glas

(a) RESIDENCE. No. 34 S 2nd ST.; Brooklyn WARD.

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 26 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Brooklyn Md
(State or country)

PARENTS

10 NAME OF FATHER John J. Glas

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md

12 MAIDEN NAME OF MOTHER Daisy Lowman

13 BIRTHPLACE OF MOTHER (city or town) Brownsville
(State or country) Md

14 Informant John J. Glas
(Address) 34 S Second St

15 Filed JUL 30 1920 ROBERT J. SLATER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28th 1920

17 I HEREBY CERTIFY, That I attended deceased from July 26th, 1920, to July 28th, 1920, that I last saw h alive on July 28th, 1920, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Diarrhoea and Enteritis

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted If not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Harry Pleibel M. D.

7/30, 1920 (Address) 1004 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: CEDAR HILL. DATE OF BURIAL: JUL 30 1920

20 UNDERTAKER JOHN F. DENNY ADDRESS 715 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45242

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45242

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 416 S. Fourteenth ST.; N WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara H. Heimiller.

(a) RESIDENCE. No. 416 S. Fourteenth ST., 26 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. N ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 13-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None ppo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Heimiller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Margaret E Bauman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant William Heimiller

(Address) 416 S. 14th St.

JUL 30 1920

ROBERT P. KRAUTH

Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1920.

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1920, to July 28, 1920.

that I last saw her alive on July 27, 1920.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Ethanation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) U L Trumbion, M. D.

7/29. 1920 (Address) 2013 Banks.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	July 30th 1920
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D45243 HEALTH DEPARTMENT—CITY OF BALTIMORE. D45243

CERTIFICATE OF DEATH. X 20

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. C

CITY OF BALTIMORE: (No. 1117 Linsian ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Mathews

(Residence in Baltimore: No. Ruxton Md. St.; 3 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. November 8th, 1905. (Month) (Day) (Year)

7-AGE. 14 yrs. 8 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry T. Mathews

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Louise Freeman

13-BIRTHPLACE OF MOTHER (State or Country). Connecticut

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Dugan

(Address) 1117 Linsian St.

15- Filed JUL 30 1920, 191.. ROBERT S. KRAUTER Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 29th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 27 1920, to July 29 1920, that I saw h[illegible] alive on July 29th 1920, and that death occurred, on the date stated above, at 2.07 p.m.

The CAUSE OF DEATH* was as follows:

General Septicaemia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Lupus Erythematosus

(Duration) yrs. mos. 10 ds.

(Signed) Walter Dugan M. D.

July 29, 1920. (Address) 1117 Linsian St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death [illegible] yrs. [illegible] mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence Ruxton Md.

19-PLACE OF BURIAL OR REMOVAL. Friends Cem DATE OF BURIAL. July 31, 1920

20-UNDERTAKER Henry W. Jenkins Sons ADDRESS Mitchell Orchard

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45244 HEALTH DEPARTMENT—CITY OF BALTIMORE D45244

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 Paradise Court ST.) (70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Butler

(a) RESIDENCE. No. 1603 Paradise Court ST.... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 31-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	-	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Born 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Elias Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliz Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elias Butler (Address) 1603 Paradise Court

15 Filed JUL 30 1920 ROBERT P. PRUTER Registrar Burial Permit (Record)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1920

17 I HEREBY CERTIFY, That I attended deceased from July 26 1920, to July 27 1920, that I last saw h er alive on July 27 1920, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Illeo Colitis

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinique

(Signed) Elias P Clanton M. D.

July 27 1920 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 30 1920
20 UNDERTAKER Samuel T Hensley	ADDRESS 578 Hanover

Spec.—6-9-19—H. P. Co.—1000 Bks.

045245

HEALTH DEPARTMENT—CITY OF BALTIMORE

045245

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 Ridgley ST. 21 WARD)

2-FULL NAME Wm Thos. Brown

(a) RESIDENCE. No. 1126 Ridgley ST., 21 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 5-19

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER W. D. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentoo Md

12 MAIDEN NAME OF MOTHER B. Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentoo Md

14 Informant Mrs. Brown (Address) 1126 Ridgley

15 Filed JUL 30 1920 ROBERT J. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1920

17 I HEREBY CERTIFY, That I attended deceased from July 14 1920 to July 29 1920

that I last saw h[illegible]ive on July 29 1920

and that death occurred, on the date stated above, at 8 30 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Schwerenbauy M. D.

, 19 (Address) 11 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	7/30 1920
20 UNDERTAKER	ADDRESS
Wm J. E. Cramden	1420 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Josephine M Reynolds

1045246

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045246

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Jos. M Reynolds 436 S Parkish ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 436 S Parkish WARD. 20

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 11-20

7 AGE: Years | Months: 4 | Days: 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 001

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto MD

PARENTS

10 NAME OF FATHER: C C Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto MD

12 MAIDEN NAME OF MOTHER: Liz Grogan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): MD

14 Informant: C C Reynolds (Address) 436 S Parkish

15 Filed JUL 30 1920 ROBERT T. LAUTER Registrar

Burial Permit Oleet

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1920

17 I HEREBY CERTIFY, That I attended deceased from July 24 1920 to July 29 1920 that I last saw h[illegible] alive on July 29 1920 and that death occurred, on the date stated above, at 12 M 9 m.

The CAUSE OF DEATH* was as follows:

Pulmo Colitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Schwarmsberg, M. D.

19 (Address) 1120 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	July 31 1920
20 UNDERTAKER	**ADDRESS**
John J Cannon & Son	901 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45247 HEALTH DEPARTMENT—CITY OF BALTIMORE D45247

CERTIFICATE OF DEATH. X 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp, ST.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Brookhart

(a) RESIDENCE. NO. Towson Md ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6m ds. How long in U. S., if of foreign birth? 6y yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1833 Aug 13

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	86	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Work 000

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Hanover Penn

PARENTS

10 NAME OF FATHER Jacob Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER Catharine Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Thomas Brookhart
(Address) Lindale Farm Towson

15 Filed JUL 30 1920 E. B. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1920

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1920, to July 29, 1920, that I last saw h alive on July 29, 1920, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Frank C Musser, M. D.

July 29, 1920 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salem Cemetery Harford Co	July 31 1920
20 UNDERTAKER	ADDRESS
J Ley Burns Sons	Towson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D45248 HEALTH DEPARTMENT—CITY OF BALTIMORE D45248

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1331 N. Stricker, ST.; 15 79 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Peters

(Residence in Baltimore: No. 1331 N Stricker St.; 46 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug (Month) 20 (Day), 1874 (Year)

7-AGE, 45 yrs. 11 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Mortimore Peters

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Jane Sars

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Peters

(Address) 1331 N. Stricker st

15-

Filed JUL 30 1920, ROBERT T. LAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 28th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 7 1920, to July 28th 1920, that I saw him alive on July 27th 1920, and that death occurred, on the date stated above, at 2P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation of Heart

(Duration) yrs. 7 mos. 15 ds.

CONTRIBUTORY (Secondary) Not known

(Duration) yrs. mos. ds.

(Signed) Harry F. Brown M. D.

July 29 1920 (Address) 1501 Prestman st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Brew Hillen, Annap's Co. DATE OF BURIAL, July 31, 1920

20-UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D45249

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45249

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 Wayne ST.; 21 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Tyler

(Residence in Baltimore: No. 612 Wayne St.; 45 yrs., ... mos. ... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 18th, (Month) (Day) 1870 (Year)

7-AGE, 50 yrs. 4 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Tyler

(Address) 612 Wayne St

15- Filed JUL 30 1920, 191... ROBERT B BEAUTER Registrar.

Burial Permit Only

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 29, (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29 1919, to July 29 1920, that I saw h[illegible] alive on July 28 1920 and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows: Thrombosis Cerebral

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) 1 yrs. ... mos. ... ds.

(Signed) C. N. Foster M. D.

July 29, 1920 (Address) 715 S Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, July 31, 1920

20-UNDERTAKER Geo. W. Holland — ADDRESS 1631 Bond Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45250

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45250

CERTIFICATE OF DEATH.

89

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mount Hope Retreat ST.: 18 WARD)

2-FULL NAME Susan B. Jenkins

(a) RESIDENCE. NO. 516 Montford ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 0 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married -

5a If married, widowed, or divorced (or) WIFE of Mr Jenkins -

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
48	0	0	0	

8 OCCUPATION OF DECEASED

037

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis Amend

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Schibler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Balto. Md.

15 Filed JUL 30 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30th 1920

17 I HEREBY CERTIFY, That I attended deceased from Apr 26 - 1911, to July 30th, 1920, that I last saw her alive on July 29th, 1920, and that death occurred, on the date stated above, at 4.55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis -

(duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) Chr- Melancholia

(duration) 9 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

July 30th 1920 (Address) Mt Hope Retreat - Balto. Md -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 2 1920
20 UNDERTAKER	ADDRESS
F. J. Brauer & Son	Frank Flannery

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of the DISEASE or STATE OF CONDITION is very important. See instructions on back of certificate.

D.45251 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45251

CERTIFICATE OF DEATH. 167

REGISTERED NO. C.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Dezyl.

(Residence in Baltimore: No. 1122 Proctor St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F	W.	Single

6-DATE OF BIRTH March 15, 1917
(Month) (Day) (Year)

7-AGE, 3 yrs. 4 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work - 000
(b) General nature of industry, business, or establishment in which employed (or employer) -

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Claude Dezyl

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Della

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary Dezyl
(Address) 1122 Proctor St

15-
Filed JUL 30 1920, 191 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7 (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to d. death on the day stated above.

THE CAUSE OF DEATH* was as follows:
Accidental Burns
(Duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Shock
(Duration) yrs. mos. ds.
(Signed) Geo Clinton Blake M. D.
(Coroner)
7/29/20 (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?....
Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Vincent Cemetery	July 31 1920
20-UNDERTAKER	ADDRESS
Deage & Ruth	1735 Harford

NOTE.—Information should be carefully supplied. All of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificate.

Spec.—6-9-19—II. P. Co.—1000 Bks.

Rukowicz

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45252

CERTIFICATE OF DEATH

D.45252

REGISTERED NO. 104

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 511 S. Ann St ST.: 2 WARD)

2-FULL NAME Eddie Rukowicz

(a) RESIDENCE. NO. 511 S Ann St ST., 2 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 16-1920.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6 Mos	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ppp

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Alex. Rukowicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Ann Kolonosh.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Husband

15 Filed JUL 30 1920 By Robert P. Harrison, Registrar
(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28" 1920.

17 I HEREBY CERTIFY, That I attended deceased from July 21 1920, to July 28 1920,
that I last saw h/er alive on July 28 1920,
and that death occurred, on the date stated above, at 800 P m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Haemorrhage from bowels

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H W. Wheaton, M. D.

, 19 (Address) 500 Cathedral Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	July 31- 1920
20 UNDERTAKER	ADDRESS
M. J. Sadowski.	900 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-1—M. & T.—2000 Blks.

D. 45253 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 45253

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH Cherry Hill Road REGISTERED NO. C

CITY OF BALTIMORE: (No. near Obrien Park ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Marie Persino

(Residence in Baltimore: No. Cherry Hill Road St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	White	Single

6-DATE OF BIRTH, 2 (Month) 28 (Day), 1920 (Year)

7-AGE, yrs. 5 mos. 1 ds.; If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), OBrien Park M.d.

PARENTS.

10-NAME OF FATHER, Edw. F Persino

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Florence Schuh

13-BIRTHPLACE OF MOTHER (State or Country), Indiana

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw. F. Persino

(Address) Cherry Hill Road

15- JUL 30 1920 Robert P. Harrison, Registrar.
Filed ....., 191.....
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7 (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15 1920, to July 28 1920, that I saw her alive on July 25 1920, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Thos. E. Hull M. D.

7-30, 1920 (Address) Hale Maryland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, July 31, 1920

20-UNDERTAKER J. Sander Sons ADDRESS 1710 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45254 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45254

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH — Highlandtown — REGISTERED NO.

CITY OF BALTIMORE: (No. 108 N. Eight St.: N Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude East

(a) RESIDENCE. No. 108 N. Eight St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of Jacob East

6 DATE OF BIRTH (month, day, and year) June 5, 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	86	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Adam Marschall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Catherine Westervelt

(Address) 108 N. Eight St

15 Filed JUL 30 1920 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1920

17 I HEREBY CERTIFY That I attended deceased from June 20, 19..., to July 27, 19..., that I last saw her alive on July 27, 19..., and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis,

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? does know.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. Hunt Straley M. D.

(Address) 2938 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Matthews Cem.	Aug 1st 1920
20 UNDERTAKER	ADDRESS
J. Sander Sons	1720 Park

mation should be carefully supplied. Age should be stated EXACTLY. Any information that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec —5-19-13—M. & T.—500 Bks.

D.45255 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45255

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2407 Christian ST.; 20 WARD) REGISTERED NO. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Manora, Finn

(Residence in Baltimore: No. 2407 Christian St St. 20 yrs.. mos. ds.)

N.B.—Every item in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) about (Day) 1851 (Year)

7-AGE, 69 yrs. mos. ds.

If LESS than 1 day. hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). Home

9-BIRTHPLACE, (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Ireland.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nora Larkin

(Address) 2407 Christian St.

15- JUL 31 1920 191..... Robert P. Harrison, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 29. (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 25 1920, to July 29 1920, that I saw her alive on July 29. 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Weakness 2.

(Duration) yrs. mos. ds.

(Signed) A. D. Driscoll M. D.

7/30, 1920 (Address) 211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, July 31. 1920

20-UNDERTAKER Harry H. Witzke — ADDRESS 1531 W Lombard

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45256

HEALTH DEPARTMENT—CITY OF BALTIMORE

152 D 45256

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 Hess Court St.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Jones

(a) RESIDENCE. No. 124 Hess Court St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 00

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): 125 Hess Court Baltimore Maryland

PARENTS

10 NAME OF FATHER: Louis Jones

11 BIRTHPLACE OF FATHER (city or town) East Orange (State or country) New Jersey

12 MAIDEN NAME OF MOTHER: Estelle Hallis

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant: Louis Jones
(Address) 124 Hess Court

15 Filed JUL 31 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29th 1920

17

I HEREBY CERTIFY, That I attended deceased from July 29, 1920, to July 29, 1920, that I last saw him alive on July 29, 1920, and that death occurred, on the date stated above, at 11 35 A m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. H. Douglass, M. D.

July 29 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 31 1920
20 UNDERTAKER	ADDRESS
A. L. Brown & Son	108 W. Monto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D45257

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45257

CERTIFICATE OF DEATH.

104

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 634 W. Montgomery St. ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard White. (C)

(Residence in Baltimore: No. 634 W. Montgomery St.

St.: yrs. 7 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH. December 13th. 1919., 1 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
.....yrs. 7 mos. 17 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Robert White. (C)

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Elsie Cornish. (C)

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert White (C) father.

(Address) 634 W. Montgomery St.

15- Filed JUL 31 1920, 191.....

G. H. Gress Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 30th. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....Cholera Infantum.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

July 30, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	July 31, 1920
20-UNDERTAKER Jno. A. Toadvine	ADDRESS 142 Eutaw St

N. B. Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D45258

HEALTH DEPARTMENT—CITY OF BALTIMORE

103 D45258

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1370 N. Calhoun ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Chase

(a) RESIDENCE. NO. 1370 N. Calhoun ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: John W. Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Emma F. Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Robert Chase
(Address) 1370 Calhoun St

15 Filed JUL 31 1920

G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28th 1920

17 I HEREBY CERTIFY That I attended deceased from July 20th 1920 (to) July 28th 1920.
That I last saw her alive on July 27th 1920.
and that death occurred, on the date stated above, at 9.30 A. m.
The CAUSE OF DEATH* was as follows:

Acute Gastritis 0783

CONTRIBUTORY (Secondary) Exhaustion & Cardiac Syncope (duration) 7 yrs. mos. 7 ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Geo. H. Lafferbach M. D.

1920 (Address) 2215 N. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick City. Md	July 1 1920

20 UNDERTAKER: Jno. A. Bradman ADDRESS 142 N. Mich St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45259

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 45259

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1834 Harford Ave ST.; 9 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard A. Shilkens

(a) RESIDENCE. No. 1834 Harford Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 29 1920

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Bernard A Shilkens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth A. Feldt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. Bernard A Shilkens
(Address) 1834 Harford Ave

15 Filed JUL 31 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1920

17 I HEREBY CERTIFY, That I attended deceased from July 26 1920, to July 30 1920, that I last saw him alive on July 30 1920, and that death occurred, on the date stated above, at 10 45 a. m.

The CAUSE OF DEATH* was as follows:

Gastric Enteric Cholera

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred J. Sloan, M. D.

(Address) 1501 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 31 1920
20 UNDERTAKER	ADDRESS
Henry Hoeck & Son	1301 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45260

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. Burial 151

D 45260

REGISTERED NO.

1-PLACE OF DEATH Robt Garrett Hosp

CITY OF BALTIMORE: (No. 29 N. Carey ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Kimes

(a) RESIDENCE. NO. 29 N Carey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 30 - 1920

7 AGE Years Months Days If LESS than 1 day, 6 hrs. or 3 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Howard Kimes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Nadia Crossnea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Nadia Kimes
(Address) 29 N Carey St

15 Filed JUL 31 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/30/20 19

17 I HEREBY CERTIFY, That I attended deceased from 7/30, 1920, to 7/30/20, 19..., that I last saw h alive on 7/30/20, 19..., and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Asbestosis

+Prematurity

(duration) yrs. — mos. ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Bernard Jotter, M. D.

7/30, 1920 (Address) 910 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem

DATE OF BURIAL: 7-30 1920

20 UNDERTAKER: Robt Brooks & Son

ADDRESS 17 Calhoun St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45261 D45261

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6 104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2004 Orleans ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Jensen

(a) RESIDENCE. No. 2007 Orleans ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 2-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Herman Jensen

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Buck

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mary Jensen (Address) 2007 Orleans

15 Filed JUL 31 1920 G. H. Gr... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1920

17 I HEREBY CERTIFY, That I attended deceased from July-23-1920, to July-20-1920, that I last saw her alive on July-20-1920, and that death occurred, on the date stated above, at 11 30 a m.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Cholera Infantum

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) William H. Johnson, M. D.

(Date) July 30. 1920 (Address) 2016 Guilford Ave.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	July 31 1920
20 UNDERTAKER J Herwig & Co	ADDRESS 2808 Elm...

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D

D 45262 HEALTH DEPARTMENT—CITY OF BALTIMORE 45262

CERTIFICATE OF DEATH.

304

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 E. Lanvale ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marguerite Edith Hecker

(a) RESIDENCE. No. 304 E. Lanvale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 5 - 1920

7 AGE Years 1 Months Days 56 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work DOD

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm Hecker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Helen Kuhl

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

13 Informant Wm Hecker

(Address) 304 E Lanvale

15 Filed JUL 31 1920 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1920, to July 31, 1920, that I last saw her alive on July 31, 1920, and that death occurred, on the date stated above, at 7 55 A m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. 1/2 mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? at Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lloyd F Singler M. D.

, 19 (Address) 2067 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Aug 3/ 1920

20 UNDERTAKER: Daniel Easton — ADDRESS: 911 Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45263

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 74 D 45263

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry A Kepple

(a) RESIDENCE. NO. ..... ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mildred B. Kepple

6 DATE OF BIRTH (month, day, and year) Nov 25 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER George W Kepple

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Midred Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Record John Hopkins Hosp (Address)

15 Filed JUL 31 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1920

17 I HEREBY CERTIFY, That I attended deceased from July 28 1920 to July 30 1920 that I last saw h— alive on July 30 1920 and that death occurred, on the date stated above, at 5.55 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Operation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of today

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W E Stanley Jr, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chicora Pa	July 31 1920
20 UNDERTAKER	ADDRESS
John D. Mitchell	1201 N Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45264

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45264

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth Burgan.

(a) RESIDENCE. No. 1805 E. Lafayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Franklin S. Burgan

6 DATE OF BIRTH (month, day, and year): July 25 - 1857

7 AGE: Years 63 — Months — — Days 6 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Phila. Pa.

PARENTS

10 NAME OF FATHER: Jos. P. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila. Pa.

12 MAIDEN NAME OF MOTHER: Ellen Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Phila. Pa.

14 Informant (Address): Franklin S. Burgan 1805 E. Lafayette

15 Filed . 19 JUL 31 1920 Registrar G. H. Gross

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30 1920

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1920, to July 30, 1920, that I last saw her alive on July 30, 1920, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Cystitis - (Duration) 3 yrs. mos. 20 ds.
Pyonephritis (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (Duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of July 6, 1920

Was there an autopsy? ~~Clinical~~ No

What test confirmed diagnosis? Clinical

(Signed) H. B. McElwee, M. D.

, 19 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 2 1920

20 UNDERTAKER: John O. Mitchell ADDRESS: North Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Wm. Howard.

D 45265 HEALTH DEPARTMENT—CITY OF BALTIMORE 15 √D 45265

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2876 Dulan ST. 1 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Howard

(Residence in Baltimore: No. 2876 Dulan St St.; yrs., 1 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Sing'l

6-DATE OF BIRTH, July (Month) 13 (Day), 1920 (Year)

7-AGE, ...yrs. ....mos. 16 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Howard

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Minnie Neal

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Howard

(Address) 2876 Dulan St.

15- Filed JUL 31 1920 G. H. Grese Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Premature Birth

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry Swan Jr. M. D. (Coroner.)

July 31, 1920. (Address) 1610 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem — DATE OF BURIAL, July 31, 1920

20-UNDERTAKER Stephen J Fialkowski — ADDRESS, 1000 Hanover St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

945266 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 945266

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1741 N. Luzerne Ave. St.) (6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Russell

(a) RESIDENCE. No. 1741 N. Luzerne Ave St.,

(Usual place of abode) WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced

Husband of Michael Russell

6 DATE OF BIRTH (month, day, and year) Feb 22, 1844

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
76	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Fitzpatrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Fitzpatrick

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Ireland

14 Informant Mrs. Mamie Reinhart

(Address) 441 N. Luzerne Ave.

15 Filed JUL 31 1920 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1920

17 I HEREBY CERTIFY, That I attended deceased from July 21 = 20 to July 30 = 20

that I last saw her alive on July 30 = 20

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH was as follows:

Apoplexy

Cerebral Hemorrhage

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas. H. A. Meyer, M. D.

31. 19 20 (Address) 1031 N. Caroline St.

•State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn

DATE OF BURIAL Aug 2 1920

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 Eager

CAUSE should be stated PLAINLY. PHYSICIANS so that it may be properly classified. Exact statem TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45267 D 45267

CERTIFICATE OF DEATH.

X 1258

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S.P.H.S.Hospital #56 ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John E. Pilcher

(Residence in Baltimore: No. U.S.P.H.S.Hospt. #56, Fort McHenry St.; ....yrs., ...mos. ....da.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ...Unknown.... (Month) ....(Day), 1865 (Year)

7-AGE, 55 yrs. ---mos. ---ds. If LESS than 1 day, ...hrs. or ....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seaman
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward T. Rawsworth Registrar

(Address) Fort McHenry Md.

15- JUL 31 1920 G. H. Grace

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...July 30, 1920 (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 21 1920, to July 30, 1920, that I saw him alive on July 30, 1920, and that death occurred, on the date stated above, at 2:30 P.m.

The CAUSE OF DEATH* was as follows:

....Fistula of bladder (Supra pubic)....

(Duration) ....yrs. 3 mos. ....da.

CONTRIBUTORY (Secondary)

(Duration) ---yrs. 3 mos. ....da.

(Signed) J. D. Pilchard M. D.

....., 191... (Address) U.S.P.H.S. Hospital #56 Fort McHenry Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ---yrs. ---mos. 10 ds. In the State Md ---yrs. ---mos. 10 ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Unknown

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery — DATE OF BURIAL, July 31, 1920

20-UNDERTAKER J. Fenton & Bro — ADDRESS 1127 E Balto St.

Spec.—5-24-14—M. S. V.—3000 blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

245268

CERTIFICATE OF DEATH.

150 245268

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Division ST.; 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME None

(Residence in Baltimore: No. 1606 Division St.; ....yrs.,....mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July (Month) 16 (Day), 1920 (Year)

7-AGE, ...yrs....mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Albert Coltman

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mabel Lee

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Coltman

(Address) 1606 Division St.

15- Filed JUL 31 1920, 191.... G. H. Gross. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 16 1920, to July 29 1920, that I saw h[illegible] alive on July 29 1920, and that death occurred, on the date stated above, at 12-30 m.

The CAUSE OF DEATH* was as follows:

Mal formation

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) T. E. Daughtry M. D.

....., 191... (Address) 1602 Pennsy Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters — DATE OF BURIAL, Aug 2, 1920

20-UNDERTAKER James E. Wright — ADDRESS 1364 Carey St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45269 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓45269

CERTIFICATE OF DEATH.

96

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1125 Myrtle Av ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis H Weyhausen

(a) RESIDENCE. NO. 1125 Myrtle Av ST., 17 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector of Foot away

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Gerhard Weyhausen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lizzie Pieper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo L. Hofmeister

(Address) 2625 Eastern Ave

15 Filed JUL 31 1920 G. H. Cross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1920

17

I HEREBY CERTIFY, That I attended deceased from July 19, 1920, to July 29, 1920, that I last saw him alive on July 29, 1920, and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

over

Bronchial asthma & emphysema

(duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute dero. fibrosis pleurisy (duration) ... yrs. ... mos. 21 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jonas U. Todd, M. D.

730. 1920 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Aug 1 1920
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1827 W North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45270

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

104 D45270

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1035 W Barre St ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Allen Baesch

(a) RESIDENCE. No. 1035 W. Barre ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 20, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore MD
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Baesch

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rose Bafford

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co
(State or country) Md

14 Informant Charles Baesch
(Address) 1035 W. Barre St.

15 Filed JUL 31 1920 19 G. H. Gresc Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1920

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1920, to July 29, 1920, that I last saw him alive on July 28, 1920, and that death occurred, on the date stated above, at 4.30 A M.

The CAUSE OF DEATH* was as follows:

Acute Ileo, Colitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Grundhs M. D.

7.29.20 (Address) 517 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Sat. July 31, 1920	19

20 UNDERTAKER J.B. Cook ADDRESS J.B. Cook. 1003 W. Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-8-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45278

CERTIFICATE OF DEATH.

104 D 45278

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 442 S Furrow ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Bernadine Schmidt

(a) RESIDENCE. No. 442 S Furrow ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 9 mos. 21 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~

6 DATE OF BIRTH (month, day, and year) Oct 9, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		9	21	

8 OCCUPATION OF DEECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer ~

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jesse B Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elsie J. Carey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Jesse B. Schmidt 442 S. Furrow St

15 Filed ..... 19 ..... Registrar

JUL 31 1920 C. H. Grese.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to July 30, 1920, that I last saw her alive on July 29, 1920, and that death occurred, on the date stated above, at 10.30 a m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) ..... yrs. ..... mos. 6 hrs

CONTRIBUTORY (Secondary) Cholera Infantum

(duration) ..... yrs. ..... mos. 30 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? ~ Date of ~

Was there an autopsy? ~

What test confirmed diagnosis? ~

(Signed) Wm A. O'Neill M. D.

7/31, 1920 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	July 31 1920

20 UNDERTAKER Joseph L Black ADDRESS 1003 W Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45272

HEALTH DEPARTMENT—CITY OF BALTIMORE D 45272

CERTIFICATE OF DEATH.

1920

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 N. Payson St. 16 WARD)

2-FULL NAME Mrs. Elizabeth Foote

(a) RESIDENCE. No. 1006 N. Payson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. L. Foote

6 DATE OF BIRTH (month, day, and year) Nov 26 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Emmitsburg Md

PARENTS

10 NAME OF FATHER Charles Nicholas Spalding

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie E. Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James H. L. Foote (Address) 1006 N. Payson St

15 Filed JUL 31 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1920

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1920, to July 30, 1920, that I last saw her alive on July 29, 1920, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. C. Pilcher, M. D.

, 19 (Address) 817 Hamilton Terr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Aug 2 1920
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 W. Balto.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

845273

CERTIFICATE OF DEATH.

150 845273

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1001 Russell St. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Erman C. Bailey.

(Residence in Baltimore: No. 1001 Russell St. St.; ~~yrs.~~ ~~mos.~~ 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, July 29th. 1920., 1
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
~~yrs.~~ ~~mos.~~ 1 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Charles Bailey.

11-BIRTHPLACE OF FATHER (State or Country), Pittsburg, Pa.

12-MAIDEN NAME OF MOTHER Rose F. Gick.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose F. Bailey. (mother)

(Address) 1001 Russell St.

15-

Filed JUL 31 1920, 191.....C. H. Grese.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 30th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
congenital.

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

July 30, 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cm.	July 31 1920
20-UNDERTAKER, Chas. W. Dill.	ADDRESS, 3109 Fredk Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

845274

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

845274

150

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1001 Russell Street. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vernon A. Bailey. ---------- 1.

(Residence in Baltimore: No. 1001 Russell Street. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, July 29th, 1920. (Month) (Day), 1 (Year)

7-AGE, ------ yrs. ---- mos. 1 ds. If LESS than 1 day, 20 hrs. or ---- min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None. 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Charles Bailey.

11-BIRTHPLACE OF FATHER (State or Country), Pittsburg Pa.

12-MAIDEN NAME OF MOTHER Rose F. Gick.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose F. Bailey (mother).

(Address) 1001 Russell Street.

15-

Filed JUL 31 1920 191 C. H. Grace, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 30th, 1920. (Month) (Day), 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital
(Duration) ---- yrs. ---- mos. ---- ds.

CONTRIBUTORY (Secondary) ----
(Duration) ---- yrs. ---- mos. ---- ds.

(Signed) Otto M. Eyerbach M. D. (Coroner.)

July 31, 1920. (Address) 1517 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ---- yrs. ---- mos. ---- ds. In the State ---- yrs. ---- mos. ---- ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem.	July 31, 1920
20-UNDERTAKER Chas. W. Dill	ADDRESS 3109 Fredk. Ave
3109 Fredk. Ave	Fredk. Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45275

3 V D 45275

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 807 N. Lakewood ave ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F Gettemuller

(a) RESIDENCE. No. 807 N. Lakewood ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 3 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Lily V. Gettemuller

6 DATE OF BIRTH (month, day, and year) April 18th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Constable 082

(b) General nature of industry, business, or establishment in which employed (or employer) Police Court

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Herman H Gettemiller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Kalmey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Lily V Gettemuller

(Address) 807 N Lakewood ave

15 Filed JUL 31 1920 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 19..

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to July 29, 1920, that I last saw him alive on July 29, 1920; and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Lumbar Abscess

(Mixed infection)

(duration) yrs. mos. 29 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Lutherwood

Did an operation precede death? Yes Date of July 10/20.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Henry V Gettemuller, M. D.

7/30. 1920 (Address) 2004 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug 2nd 1920
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

045276

CERTIFICATE OF DEATH.

045276

REGISTERED NO. C 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25 ½ N. Exeter ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Ruby Wahman

(Residence in Baltimore: No. 25 ½ N. Exeter St.; ...yrs., mos. ... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July (Month) 31 (Day), 1920 (Year)

7-AGE, ...yrs. ...mos. ...da. If LESS than 1 day, ...hrs. or ...min.? 5 min

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... None
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, Samuel Wahman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Bessie Waxman

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Balto

15-

Filed JUL 31 1920, 19... C. H. Cresse Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 31 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1920, to July 30 1920, that I saw him alive on , , 192 , and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Prob. Coll. Stomach

(Duration) ...yrs. ...mos. 1 da.

CONTRIBUTORY (Secondary) ...

(Duration) ...yrs. ...mos. ...da.

(Signed) A. J. Gordon M. D.

July 31, 1920 (Address) 918 E Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Lehren Rosedale

DATE OF BURIAL, July 31, 1920

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto

N.B.—Exact date of birth must be stated. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D45277

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45277

CERTIFICATE OF DEATH.

REGISTERED No. C 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1838 E. Dover St., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth M. Lauenwald.

(Residence in Baltimore: No. 1838 Dover St.; \ yrs., \ mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6-DATE OF BIRTH: July 18, 1907 (Month) (Day) (Year)

7-AGE: ..yrs..mos. 13 ds. If LESS than 1 day, ...hrs. or, ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country): Balto

PARENTS.

10-NAME OF FATHER: Chas. F. Lauenwald

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Marie Lorenz

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles F. Lauenwald

(Address) 1838 Dover St

15- Robert P. Harrison, Registrar.
Filed AUG 1 1920, 191.... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: July 31, 1907 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 27, 1910, to July 31, 1907, that I saw her alive on July 31, 1907, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(Duration) ..yrs..mos. 13 ds.

CONTRIBUTORY (Secondary) Inanition

(Duration) ..yrs..mos. 13 ds.

(Signed) [illegible] M. D.

July 31, 1907. (Address) 1933 Ellamont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Olivet. DATE OF BURIAL: Aug 2, 1907

20-UNDERTAKER: George J. Smith ADDRESS: 1000 E. Fayette St

N. B.—Every item of information above must be carefully supplied. AGE should be stated EXACTLY. If LESS than a day, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D45278 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45278

CERTIFICATE OF DEATH.

104

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 914 Shuter ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lloyd Cook;

(Residence in Baltimore: No. 914 Shuter St.

St.; yrs., 2 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col.	Sing.

6-DATE OF BIRTH, ... 1 (Month) 17 (Day), 1920 (Year)

7-AGE, ... yrs. 6 mos. 10 da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of Industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Geo Chase

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Laura Jalbroy

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Geo E Chase

(Address) ..... 914 Shuter St

15-

AUG 1 1920 Robert P. Harrison,

Registrar.

Burial Permit Clerk

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... da.

(Signed) ..... (Coroner.) M. D.

7-31, 1920 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cmty	July 31, 1920

20-UNDERTAKER Mrs Rolt & Rolt ADDRESS 1725 Pennsylvania Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-45279 HEALTH DEPARTMENT—CITY OF BALTIMORE J 246279

CERTIFICATE OF DEATH. X 40

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME DeWitt Woodford Jr.

(a) RESIDENCE. NO. Alpine W. Va., ST.. WARD. Alpine W. Va.,
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 10 ds. How long in U. S., if of foreign birth? 51 yrs. 5 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Woodford

6 DATE OF BIRTH (month, day, and year) Feb 4th 69

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer. 086

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer.

(c) Name of employer None.

9 BIRTHPLACE (city or town) (State or country) Garbour W. Va,

PARENTS

10 NAME OF FATHER DeWitt Woodford.

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Minnie Sipple

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant Emma E. Mylins (Address) 218 Center St Elkins W. Va.

15 Filed AUG-1 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

17 I HEREBY CERTIFY, That I attended deceased from July 21 1920, to July 31 1920, that I last saw him alive on July 31 1920, and that death occurred, on the date stated above, at 4 10 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Asystole

(duration) permanent yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastric Carcinoma.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of July 24 1920

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) A J Zeiler, M. D

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Borden W. Va.	Aug 1st 1920
20 UNDERTAKER	ADDRESS
Philip Hennig	Orleans W. Va.

mation should be carefully supplied. AGE should be stated EXACTLY. If less than a day or a year, the exact fraction should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIAN'S

AFFIDAVIT

Spec.—6-9-19—H. P. C.—1000 Bks.

D.45280 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45280

X 54

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Penland -

(a) RESIDENCE. NO. 207 Fifth Ave. ST. Knoxville Tenn. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Mary E. Penland

6 DATE OF BIRTH (month, day, and year) Jan 3-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	6.	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER John J. Penland

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Nellie Justus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tennessee.

14 Informant (Address) J. H. Reynolds

15 Filed AUG-1 1920 19..

Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

17 I HEREBY CERTIFY, That I attended deceased from July 14 1920, to July 31 1920, that I last saw h.~~e~~ alive on July 31 1920, and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia.

? (duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Tenn

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Exam.

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Knoxville Tenn	July 31 1920

20 UNDERTAKER Joseph Ahrens ADDRESS 221 N. B Way

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45281 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45281

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 906 Aisquith St.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marcin Bloom

(a) RESIDENCE. NO. 906 Aisquith St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White Male

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1845

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 900

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Lewis
(Address) 1411 E Baltimore St

15 Filed AUG 1 1920, 19

Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

17

I HEREBY CERTIFY, That I attended deceased from July 28, 1920, to July 30, 1920, that I last saw her alive on July 30, 1920, and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What tests confirmed diagnosis?

(Signed) M. Shudenoff, M. D.

, 19 (Address) 1328 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Wash Road	8/1 1920
20 UNDERTAKER: Jack Lewis	ADDRESS: 1411 E Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45282 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45282

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew aged Home for Incurables

CITY OF BALTIMORE: (No. ... ST.: W WARD) 120

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Clarael

(a) RESIDENCE. No. 2001 E Balt ST., ... WARD. .....

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 40 yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mother Of Clarael

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Lewis 1411 E Balt St

15 Filed AUG 1 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1920, to July 30, 1920.

that I last saw her alive on July 30, 1920.

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 2 yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) / yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Hugo Bangin M. D.

7/31 1920 (Address) 210 N. Front

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Hebrew Rd	8/1 1920
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 Balt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45283 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45283

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 239 S. Register ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Sedlacek

(a) RESIDENCE. NO. 239 S. Register ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 0 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Magdalena Sedlacek

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kray Secretary Bohemia

PARENTS

10 NAME OF FATHER Martin Sedlacek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Emma Kredyle

(Address) 239 S Register

15 Filed AUG 1 1920 19 Robert T. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1920

17 I HEREBY CERTIFY, That I attended deceased from July 20 . 1920. to July 30 . 1920 that I last saw h.. live on July 29 . 1920 and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J Fred Lanz M. D.

7-31. 1920 (Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL Aug 2 1920

20 UNDERTAKER Fred Enoch & Son ADDRESS 1916 Eastern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.45284 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45284

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 229 S. Collington Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Kylander

(Residence in Baltimore: No. 229 S. Collington ave St.; Life yrs.) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March (Month) 29 (Day), 1889 (Year)

7-AGE, 30 yrs. 4 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Labor
(b) General nature of industry, business, or establishment in which employed (or employer)..... Odd

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles Kylander

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Barbra Lehnman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)....Barbra Kylander.....

(Address).....229 S. Collington ave.....

15-

Filed....., 191.....

Robert P. Harrison, Registrar.

AUG-1 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 22, 1920, to July 30 1920, that I saw h M alive on July 20 1920, and that death occurred, on the date stated above at 2.35 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary & Intestinal Tuberculosis

(Duration)....yrs. 7 mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) Geo Heller M. D.

7-30, 1920 (Address) 493 Light St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Forest German V Unitarian

DATE OF BURIAL, Aug 1, 1920

20-UNDERTAKER Windell-Ruppelsdorf

ADDRESS 378 Lem

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45285

~~42 314~~
D. 45285

CERTIFICATE OF DEATH.

14-091

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Dennis.

(a) RESIDENCE. No. 318 S 14th St. Highland Town ST. Md. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11-1919

7 AGE Years 1 Months 13 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 700

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Earl Dennis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Lillian Eckel.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Att't Records
(Address)

15 Filed AUG - 1 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1920

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1920, to July 30, 1920, that I last saw h. alive on July 30, 1920, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Patient's Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stool culture.

(Signed) [illegible], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First German U Vg Church Cem Aug 1	1920
20 UNDERTAKER	ADDRESS
Wendell Pfeffel & Son	378 Penn

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

OVER

D. 45286

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45286

CERTIFICATE OF DEATH.

61-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.: 3 Ward) (Mary 3rd floor Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie Bercowitz

(a) RESIDENCE. NO. ~~#1082 Ramsey St~~ 1082 Granby St ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Benny Bercowitz

6 DATE OF BIETH (month, day, and year)

7 AGE: 35 Years — Months — Days

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): B. Bercowitz 1082 Granby St

15 Filed AUG 1 1920 Gilbert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30 1920

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1920, to July 30, 1920,

that I last saw h[illegible] alive on July 30, 1920,

and that death occurred, on the date stated above, at 1 15 a m.

The CAUSE OF DEATH* was as follows:

Epidemic Cerebro spinal Meningitis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency

(duration) yrs. 0 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Extraction of tooth.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Geyer, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	Aug. 1, 1920

20 UNDERTAKER: Max Levinson

ADDRESS 1127 E Balto St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U.S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to
pective of age. For
or term on the fir
Farmer or *Planter*,
tect, *Locomotive eng*
fireman, etc. But in
trial employments, i
kind of work and als
or industry, and the
vided for the latter s
when needed. As exa
mill; (*a*) *Salesman*,
Automobile factory.
form part of the se
"Laborer," "Forema
without more precise
Farm laborer, *Labor*
home, who are engage
only (not paid *House*
salary), may be ente
or *At home*, and child
At school or *At ho*
report specifically the
in domestic service
Housemaid, etc. If tl
or given up on accoun
state occupation at b
from business, that
Farmer (*retired*, *6 yr*
occupation whatever,

Aug. 23-1920
To whom this may concern
Retd. Certificate issued July 30 1920
in Name of Walter Bennett
Citizens Band is to be changed
to Mary Bennett

W. B. Meyer M.D.
University Hospital
Answer to letter Aug 23rd 1920
Re Mrs Walter Bennett

Statement of cause

DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); ***Measles;*** *Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory
ection need not be
e: *Measles* (disease
neumonia (second-
mptoms or terminal
"Anemia" (merely
ose," "Coma," "Con-
al," "Senile," etc.),
failure," "Hemor-
Old age," "Shock,"
a definite disease
Always qualify all
or miscarriage, as
ERAL *peritonitis*,"
ical operation was
S state MEANS OF
TAL, SUICIDAL, or
if impossible to
Accidental drown-
ccident; Revolver
d by carbolic acid
of the injury, as
es (e. g., *sepsis*,
nead of "contribu-
ement of cause of
Nomenclature of

STATEMENTS

Spec.—8-24-14—M. & T.—2000 Blks.

D.45287 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45287

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 802

CITY OF BALTIMORE: (NO. 600 N. Eden ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Israel Levinson

(Residence in Baltimore: No. 600 N. Eden St.; 40 yrs. ~~10~~ mos. ..... da.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate. OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH. Unknown (Month), ... (Day), 1 (Year)

7-AGE.	If LESS than 1 day,
61 yrs. ..... mos. ..... da.	....hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Leib Levinson

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Abe Schwartzberg

(Address) 600 N Eden St

15- Filed AUG 1 1920, 191... Robert P. Harrison, Registrar.
Burial Permit Cl

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 31 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 15 1920, to July 31 1920, that I saw h alive on July 31 1920, and that death occurred, on the date stated above, at 4 30 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Dilatation of Aortic arch
(Duration) ..... yrs. 6 mos. ..... da.

CONTRIBUTORY (Secondary) Angina Pectoris
(Duration) ..... yrs. 6 mos. ..... da.

(Signed) M D Kolodny M. D.
8/1/20..., 191... (Address) 1515 N Bentalou

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 600 N Eden St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rosedale	Aug 1, 1920

20-UNDERTAKER S. Levinson — ADDRESS 1127 E Baltimore St

STATE OF MARYLAND, Baltimore City, to wit;

I hereby certify that on this 11th day of August, 1920, before me the subscriber a Notary Public of the State of Maryland in and for the City of Baltimore aforesaid, personally appeared Doctor M.S.Koppleman and being duly sworn says;

D 45287

That he was the [illegible] physician who was called in at the time of the death of Israel Levinson who died on July 31, 1920, and that he also issued the death certificate and that he was informed by a son-in- law that the age of the deceased was 61 years and that he inserted the said age in the said certificate and that he has since been informed that the age of the deceased at death was fifty seven years and that he desires that the correct age be substituted for the one now appearing in said certificate.

As Witness the hand and seal of said affiant the day and year above written.

M. S. Koppleman (SEAL)

As Witness my hand and Notarial Seal.

M Henry Goldstein

Notary Public.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45288

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45288

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 S Montford Ave ST.; 1st WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Podowski

(Residence in Baltimore: No. 627 S. Montford St.; 53 yrs., ... mos. ..... da.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Place of death and full name of deceased must be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March 26, 1867
(Month) (Day) (Year)

7-AGE, 52 yrs. 4 mos. 4 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 640

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, John Podowska

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Julia Gackowska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Trofilena Podowska

(Address) 627 S. Montford Ave 1474

15-

Filed AUG-1 1920, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 30, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27 1920, to July 30 1920, that I saw h.r alive on July 30 1920, and that death occurred, on the date stated above, at 4 P.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Brights

(Duration) ..... yrs. Unknown mos. ..... ds.

CONTRIBUTORY (Secondary) C. Sinus

(Duration) ..... yrs. unk mos. ..... ds.

(Signed) Frank A. Kemp, M. D.

July 30, 1920. (Address) 2461 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus

DATE OF BURIAL, Aug 2, 1920.

20-UNDERTAKER M. F. Sadoski

ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

D.45289 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45289

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 S Bond ST.; 3 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Jakubowska

(Residence in Baltimore: No. 720 S Bond St.; ....yrs.,....mos.....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ~~Male~~ Female

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) ~~Married~~

6-DATE OF BIRTH, Jan (Month) 1 (Day), 1920 (Year)

7-AGE, ...yrs. 7 mos.....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Michael Jakubowska

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Anna Edwalbska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Jakubowska

(Address) 720 S. Bond St

15- Filed AUG 1 1920, 191.... Robert P. Harrison, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 31 (Day), 1920 (Year)

I HEREBY CERTIFY, That I attended deceased from July 27 1920, to July 31 1920, that I saw h[e] alive on July 31 1920, and that death occurred, on the date stated above, at ....m

The CAUSE OF DEATH* was as follows:

Acut gastro Enteritis

.....

.....

..... (Duration) ....yrs.....mos.....4.....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ....yrs.....mos.....ds.

(Signed) F Wiedemann M. D.

July 31, 1920 (Address) 1 E. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs.....mos.....ds. In the State ....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary Cem	July, 1920
20-UNDERTAKER	ADDRESS
Jacob Tidy & Sons	1128 E Baltimore St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45290

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45290

CERTIFICATE OF DEATH.

REGISTERED NO. 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Swann

(a) RESIDENCE. No. 1622 E Fayette ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31 years			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 04
(b) General nature of industry, business, or establishment in which employed (or employer) Unloading Ships
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Waldon Swann

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina.

12 MAIDEN NAME OF MOTHER Biddie Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Waldon Swann
(Address) 1624 E. Fayette St.

15 Filed AUG - 1 1920 Robert P. Garrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1920

17 I HEREBY CERTIFY, That I attended deceased from July 24 1920, to July 29 1920, that I last saw h.. alive on July 29 1920, and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Arteriosclerosis

Over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical findings

(Signed) F C Munro, M. D.

. 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
A S B Army Camp	Aug 2 1920
20 UNDERTAKER	ADDRESS
Felix B Pyle	102 E Hoff

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Extent statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No Cerebral hemorrhage.
Positively Luetic.

Spec.—8-24-14—M. & T.—2000 Blks.

D.45291

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D.45291

CERTIFICATE OF DEATH.

150

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 S Robinson ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agatha Jenkins

(Residence in Baltimore: No. 108 S Robinson St. 11 hours

St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	

6-DATE OF BIRTH, July (Month) 31 (Day), 1920 (Year)

7-AGE, ... yrs. ..... mos. 11 hours ds.

If LESS than 1 day, 11 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Richard F Jenkins

11-BIRTHPLACE OF FATHER (State or Country). Anarundel County

12-MAIDEN NAME OF MOTHER Alice Lawton

13-BIRTHPLACE OF MOTHER (State or Country). Anarundel County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Parents

(Address) 108 S. Robinson St

15-

Robert P. Harrison,

Filed ..... 191.....

AUG-1 1920

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 31 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 31 1920, to July 31 1920, that I saw her alive on July 31st 1920, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Failure of Foramen Ovale

Congenital 11 hours

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. A. Tod M. D.

....., 191... (Address) 470 N Eastern Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Trinity Cem.	Aug. 1, 1920

20-UNDERTAKER H. Sander Sons ADDRESS 1710 Lord St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45292 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45292

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3301 Piedmont Ave ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hamburger

(a) RESIDENCE. NO. 3301 Piedmont Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 2 yea 078

(b) General nature of industry, business, or establishment in which employed (or employer) Motorman

(c) Name of employer United Railway

9 BIRTHPLACE (city or town) (State or country) ~~Md~~ Baltimore Maryland

PARENTS

10 NAME OF FATHER Valentin Hamburger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Weil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Martin W. Kreft
(Address) 3301 Piedmont Ave

15 Filed AUG-1 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1920

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1920, to July 30, 1920, that I last saw h.. alive on July 30, 1920, and that death occurred, on the date stated above, at 11.45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease
Aortic & Mitral Insufficiency
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Edgar Madge M. D.

, 19 (Address) 3409 Piedmont Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug. 2 1920
20 UNDERTAKER H. Sander Sons	ADDRESS 1700 Rut

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45293 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45293

CERTIFICATE OF DEATH.

X 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Skaner

(a) RESIDENCE. No. Bradshaw Md St., WARD. Bradshaw Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? 20 yrs. mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~ 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardner

(b) General nature of industry, business, or establishment in which employed (or employer) G. 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs P Whitten
(Address) Bradshaw

15 Filed AUG 1 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1920, to July 31, 1920, that I last saw him alive on July 31, 1920, and that death occurred, on the date stated above, at 9.30a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Work (duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Xray

(Signed) [illegible] M. D.

. 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Joseph's Cemetery	Aug 1 1920
20 UNDERTAKER	ADDRESS
Howard K McKenna	Aberdeen

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. For statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45294 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45294

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 East St. ST.: 3 WARD) REGISTERED NO. 1047

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gina Marinone

(a) RESIDENCE. No. 418 East ST., WARD. New York N.Y.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 20-1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...601...

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York N.Y.

PARENTS

10 NAME OF FATHER Salvatore Marinone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Concetta Stabile

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Salvatore Marinone
(Address) 418 East St.

15 Filed AUG-1 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

17

I HEREBY CERTIFY, That I attended deceased from July 18 1920 to July 31 1920

that I last saw her alive on July 31 1920

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Acute Ileo Colitis

(duration) yrs. 14 mos. ds.

CONTRIBUTORY (Secondary) Acute Acidosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) Fred Ruzicka M. D.

(Address) 800 N. Patterson Okmulgee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Hebron Cemetery	Aug. 1 1920
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Hoffman Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.45295 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45295

CERTIFICATE OF DEATH. X 104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 East St.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexandro Maimone

(a) RESIDENCE. No. 418 East St.; WARD. New York, N.Y.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 20-1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — DD

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New York. N.Y.

PARENTS

10 NAME OF FATHER Salvatore Maimone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Concetta Vitale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Salvatore Maimone
(Address) 418 East St.

15 Filed AUG-1 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July Aug 1 - 1920

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1920, to July Aug 1, 1920 that I last saw h[illegible] alive on July 31, 1920 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Acute Ulcerative Ileo Colitis

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Acidosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Fred Buzzard, M. D.

1, 1920 (Address) 222 N Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincent Cemetery	Aug. 1 1920
20 UNDERTAKER	ADDRESS
George J. Roth	1755 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45246 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45296

CERTIFICATE OF DEATH. 105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5118 Wayne Av. ST.; 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen McClymont

(a) RESIDENCE. No. 5118 Wayne Av ST., 27 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred About 72 yrs. ? mos. ? ds. How long in U. S., If of foreign birth? abt 72 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) ? ? ? About 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	About 72	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none DOD

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Wm. McClymont

11 BIRTHPLACE OF FATHER (city or town) ? ? (State or country) Scotland

12 MAIDEN NAME OF MOTHER Elizabeth ? ?

13 BIRTHPLACE OF MOTHER (city or town) ? ? (State or country) Scotland

14 Informant Mrs Mary A. McClymont (Sister-in-law) (Address) 5118 Wayne Ave

15 Filed AUG-1 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1 1920, to July 30 1920, that I last saw her alive on July 30 1920, and that death occurred, on the date stated above, at 10 30 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Chesney Harrison, M. D.

, 19 (Address) 1227 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL Aug 2/ 1920.

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.45297

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45297

CERTIFICATE OF DEATH.

REGISTERED No. C 1047

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 McCabe Ave St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ellen Rackensperger

(Residence in Baltimore: No. 609 McCabe Ave St.; ..... yrs., 5 mos. 26 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	single

6-DATE OF BIRTH, Feby 4, 1920 (Month) (Day) (Year)

7-AGE, ... yrs. 5 mos. 26 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... NONE
(b) General nature of industry, business, or establishment in which employed (or employer) Infant

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jacob Rackensperger

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Agnes Catherine Schopper

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob Rackensperger

(Address) 609 McCabe Ave

15-

Filed AUG-1 1920, for Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 31 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 25 1920, to July 31 1920, that I saw her alive on July 30 1920, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. A. Duncan M. D.

July 31, 1920 (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? At residence

Former or usual residence 609 McCabe Ave

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery — DATE OF BURIAL, August 1, 1920

20-UNDERTAKER Henry Hoerdt Son — ADDRESS 1301 E Eager St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45298 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45298

CERTIFICATE OF DEATH.

1045

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 804 S Lakewood Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl C Deares

(a) RESIDENCE. No. 804 S Lakewood Ave., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 1919-July 10-

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	—	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Conrad Deares

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Francis Kapinalski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Francis Deares

(Address) 804 S Lakewood Ave

15 Filed AUG-1 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

17 I HEREBY CERTIFY, That I attended deceased from July 31 - 1920, to July 31 - 1920, that I last saw him alive on July 31, 1920, and that death occurred, on the date stated above, at 10.30 p m.

The CAUSE OF DEATH* was as follows:

Marasmus

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro-Enteritis

Indefinite (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) John A. Miller M. D.

19 (Address) 2739 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Aug 2 1920
20 UNDERTAKER	ADDRESS
Stephen J Fialkowski	1005 S Kenwood Ave

THIS IS A PERMANENT RECORD. ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.45299 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45299

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin SE Hospital St.: 6 WARD) 175/001 REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Barber

(Residence in Baltimore: No. 2006 Lincoln Ct. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, unknown, 1 (Month) (Day) (Year)

7-AGE. 49 yrs. mos. ds. If LESS than 1 day, hrs. or min. 040

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Balt Market

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country): unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Barber

(Address) 2006 Lincoln Ct

15- AUG 1 1920 [Robert P. Harrison,] Registrar.
Filed ....., 191.....
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 29, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of Skull
auto accident

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Fenton M. D. (Coroner.)

July 31, 1920 (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. 3 ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? North Ave & Appleton St
Former or usual residence 2006 Lincoln St.,

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Asbury Cemetery	Aug. 1, 1920
20-UNDERTAKER	ADDRESS
Milton Davis	903 N Eden St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45300

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45300

64 V

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1715 Barclay ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William West Beiermeister

(a) RESIDENCE. No. 1715 Barclay ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ Mary Beiermeister

6 DATE OF BIRTH (month, day, and year) October 5th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York N.Y.

PARENTS

10 NAME OF FATHER John Beiermeister

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Barbra Schlosser

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Mary Beiermeister

(Address) 1715 Barclay st

15 Filed AUG - 1 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

17

I HEREBY CERTIFY, That I attended deceased from June 19. 1920. to July 31st 1920.

that I last saw him alive on July 30 1920

and that death occurred, on the date stated above, at 6.15a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Paralysis

Coma

(duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. B. Fogle, M. D.

, 19 (Address) 830 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Lutheran Cemetery	Aug 3rd 1920
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.45301 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45301

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital ST.; 14 WARD) 15

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Frank

(Residence in Baltimore: No. Womans Hospital St.; 0 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, August 1, 1920
(Month) (Day) (Year)

7-AGE, 0 yrs. 0 mos. 0 ds.

If LESS than 1 day, 0 hrs. or 45 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 0 DDL
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Womans Hospital

PARENTS.

10-NAME OF FATHER, Henry L Frank

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Isabelle Kann

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Records

(Address)

15- AUG 1 1920, 191

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 1, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I saw h[illegible] alive on August 1 1920,
and that death occurred, on the date stated above, at 4.20 A m.
The CAUSE OF DEATH* was as follows:

3 months premature
Died 3/4 hour after delivery
(Duration) yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) John McC Bongard M. D.
191... (Address) 4 W Read St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).
At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bals Hebrew — DATE OF BURIAL, Aug 1 21, 1920

20-UNDERTAKER David Goodman — ADDRESS 1128 W Mt Royal

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45302 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D.45302

CERTIFICATE OF DEATH.

1202

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2798½ W. North Ave. ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Witzgall

(a) RESIDENCE. No. 2798½ W North Ave ST.

(Usual place of abode) WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 0 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Witzgall

6 DATE OF BIRTH (month, day, and year) July 28 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jacob P Meier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Schlicker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John M. Witzgall 2798½ W. North Ave

15 Filed AUG – 1 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1920

17

I HEREBY CERTIFY, That I attended deceased from May 8, 19 20, to July 29, 19 20, that I last saw h er alive on July 29, 19 20, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH was as follows:

Chronic Tubal Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O L. Long, M. D.

(Address) 2701 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Aug 2 1920
20 UNDERTAKER	ADDRESS
Wm J Fickes & Sons	North & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Examination of OCCUPATION is very important. See instructions on back of certificates.

D.45303 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45303

CERTIFICATE OF DEATH.

REGISTERED No. C 172

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1025 Druid Hill Ave St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Montgomery Jr

(Residence in Baltimore: No. 1026 Druid Hill Ave St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write One word.) Single

6-DATE OF BIRTH, Sept. 26, 1919
(Month) (Day) (Year)

7-AGE, ... yrs. 10 mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work — —
(b) General nature of industry, business, or establishment in which employed (or employer) — —

9-BIRTHPLACE, (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER, Jos Montgomery

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER May Boggs

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Montgomery

(Address) 1035 Druid Hill Ave

15- AUG - 1 1920 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7/30/1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull, accidental.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ... yrs. ... mos. ... ds.

(Signed) Geo E Pfahler M. D.
(Coroner.)

7/31/20 ... 191... (Address) 3 W Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Md Auburn Cem — DATE OF BURIAL, Aug 1 1920

20-UNDERTAKER George H Holland — ADDRESS 1631 Druid Hill Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PLACE OF DEATH should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D.45304

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45304

CERTIFICATE OF DEATH.

799

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Bromo Seltzer Tower Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Anderson

(Residence in Baltimore: No. 527 Dolphin St.; yrs., 40 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ...January... 16th ... 1861.
(Month) (Day) (Year)

7-AGE, 59 yrs. 2 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)..... United R.R. Co

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thornton Anderson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cornelia Anderson

(Address) 527 Dolphin St

15- AUG-1 1920

Filed ....., 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...July.... 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ...Inquest... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ...Inquest... (Inquest, autopsy or inquiry.) find that said deceased came to ...death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (Duration) ... yrs. Endless mos. ... ds.

(Signed) James M. Fenton M. D. (Coroner.)

July 31, 191... (Address) 2002 Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Auburn Cem. DATE OF BURIAL, Aug 2, 1920

20-UNDERTAKER George H. Holland ADDRESS 1631 Lemmon Hillman

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D45305

CERTIFICATE OF DEATH.

104 D45305

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 728 Hanover ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helena G. Jackson

(Residence in Baltimore: No. 728 Hanover St St.; 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	Col'd,	Sin,

6-DATE OF BIRTH, November 3, 1919. (Month) (Day) (Year)

7-AGE, ✓ yrs. 8 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Jackson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Annie Hardman

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Hardman

(Address) 728 Hanover St

Filed AUG 2 1920, 191.....

G. H. Cross Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 31 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 28 1920, to July 31 1920, that I saw her alive on July 30 1920, and that death occurred, on the date stated above, at 11:20 A.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Intestinal Intoxication

(Duration) yrs. mos. 5 ds

CONTRIBUTORY (Secondary) ✓

(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) D. F. Cammell M. D.

7/31, 1920 (Address) 1400 W. Hill St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Aug 2d, 1920.

20-UNDERTAKER S. E. Brown & Son ADDRESS 1017 W Monty St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45306

CERTIFICATE OF DEATH.

105 D 45306

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 Sharp St. 22 Ward)

2-FULL NAME Mary V. Brown

(a) RESIDENCE. No. 607 Sharp St. 22 Ward.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 13-1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~Mos.~~	2	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Brown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Bertha Boggs

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Washington DC

14 Informant M Brown
(Address) 607 Sharp St

15 Filed AUG 2 1920. 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

17 I HEREBY CERTIFY, That I attended deceased from July 10 1920 to July 31. 1920.
that I last saw h[illegible] alive on July 31, 1920.
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Albuminuria

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Schwarzenberg, M. D.
(Address) 1120 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Aug 2 1920
20 UNDERTAKER	ADDRESS
G. H. Brown's Son	1624 W Mont St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45307 HEALTH DEPARTMENT—CITY OF BALTIMORE D45307

154

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3303 Marshall Court ST.; 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Gracey

(a) RESIDENCE. No. 3303 Marshall Court ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cathrine Gracey

6 DATE OF BIRTH (month, day, and year) April 8 1833

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Robert Gracey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nancy Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Harry C. Blumenstock (Address) 3303 Marshall Ct.

15 Filed AUG 2 1920 G. H. Gresc. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1 1920 to July 30 1920, that I last saw him alive on July 27 1920 and that death occurred, on the date stated above, at 330 a m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A B Tilton, M. D.

7/31. 1929 (Address) 2921 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Aug 2 1920
20 UNDERTAKER Tilly and Zeiler	ADDRESS 403 E Wolfe St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45-308

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 45308

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 430 S. Fifth St. ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecilia Kappel.

(a) RESIDENCE. No. 430 S. Fifth St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 11-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER August Kappel

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Barbara Kern

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Barbara Kappel
(Address) 430 S. Fifth St.

15 Filed AUG 2 19 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

I HEREBY CERTIFY, That I attended deceased from July 31 1920, to July 31 1920.

that I last saw h[illegible] alive on July 31 1920

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis. —

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Intero Colitis & Exhaustion. —

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) C. H. Samuelson M. D.

July 2 1920 (Address) 358 Cook Ct.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem.	Aug. 7 1920
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 E. Monument St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45309

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45309

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605. S. Bond. ST.: V WARD)

REGISTERED NO. 1042

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kazmierz. Ruchlewicz.

(a) RESIDENCE. NO. 605. Bond. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Chas

6 DATE OF BIRTH (month, day, and year) Jan. 6- 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Blazej Ruchlewicz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Jozefa Riechl.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Jozefa Ruchlewicz.
(Address) 605 S. Bond. Bltz

15 Filed ..., 19 ...

AUG 2 1920 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1920, to July 31, 1920, that I last saw h— alive on July 31, 1920, and that death occurred, on the date stated above, at 1 45 m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of ...

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. Weinstein, M. D.

July 31, 1920 (Address) 165 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary.	Aug 2 1920
20 UNDERTAKER	ADDRESS
Wm Galloway	168 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45310

CERTIFICATE OF DEATH.

74 D 45310

1-PLACE OF DEATH 436 S. Augusta ave (20) REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 43 Pa[illegible] N. ST.; 4th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Charles Otto Schmidt

(Residence in Baltimore: No. 313 N. Paca St ..... St.; 42 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Married

6-DATE OF BIRTH, ... July (Month) ..... 7 (Day) ....., 1858 (Year)

7-AGE, 62 yrs. ..... 24 mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Furrier ..... do.
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Leipsig Germany

PARENTS.

10-NAME OF FATHER, Gottlieb Schmidt

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Seitler

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Augusta O. Schmidt

(Address) 313 Paca St (Same)

15-

Filed ..... AUG 2 1920 ..... 191..... G. H. Gress ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... August 1st (Month) ..... 1920 (Day) ....., 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15 1920, to Aug. 1 1920, that I saw h[illegible] alive on July 31 1920, and that death occurred, on the date stated above, at 6[illegible] A.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

..... (Duration) ..... yrs. ..... mos. 15 ds.

(Signed) Stevens J. Hahn M. D.

Aug. 1, 1920. (Address) 2 3 N Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Aug. 3, 1920
20-UNDERTAKER Louis Heemann	ADDRESS 32 S Broadway

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be stated EXACTLY. PHYSICIANS should write properly classified. Exact statement of OCCUPATION is very

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 45311

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 45311

1920

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1303 N Calvert St. WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Louisa Pratt James

(Residence in Baltimore: No. 1303 N Calvert St.: 15 yrs. mos ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word): Widowed

6-DATE OF BIRTH: Sept 24th, 1842 (Month) (Day) (Year)

7-AGE: 77 yrs. 10 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: House
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE (State or country): Louisiana

PARENTS

10-NAME OF FATHER: Enoch Hyde Jr

11-BIRTHPLACE OF FATHER (State or country): ?

12-MAIDEN NAME OF MOTHER: Susan Hyde

13-BIRTHPLACE OF MOTHER (State or country): ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry P. James

(Address) 1303 Calvert St

15. Filed AUG 2 1920, 191 G. H. Grie. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: July 31st, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28th, 1919, to July 30th 1920, that I saw her alive on July 27th, 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds

Contributory (~~SECONDARY~~) Chronic Cystitis (Severe)

(Duration) 1 yrs. mos. ds.

(Signed) Thomas L. Shearer M. D.

Aug 1st, 1920. (Address) 905 N Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Greenmount — DATE OF BURIAL: Aug 2 1920

20-UNDERTAKER: Henry H. Jenkins & Sons — ADDRESS: McCulloh & Eutaw Sts

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45312

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45312 164

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 Ostend ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl Lillian Swann

(a) RESIDENCE. NO. 1407 Ostend St ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 20/19

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
15 months				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ old

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Swann

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER E. W. Hodgman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Wm Swann 1407 Ostend St

15 Filed AUG 2 1920 G. H. Green Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

17 I HEREBY CERTIFY, That I attended deceased from July 20 1920 to July 31 1920.

that I last saw h alive on July 31 1920

and that death occurred, on the date stated above, at 1¼ a m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Dentition

(duration) yrs. 1 mos. VI ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. Upshur Dunn, M. D.

July 31 1920 (Address) 1227 Cumberland

*State the Disease Causing Death, or in Deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	8/2/20
20 UNDERTAKER	ADDRESS
Jones & Toulson	147 Saratoga

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45313

CERTIFICATE OF DEATH.

104 D 45313

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Hanover St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dwight B. Apple

(a) RESIDENCE. No. 906 Hanover St., 23 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bates
(State or country) Md.

PARENTS

10 NAME OF FATHER Theodore Apple

11 BIRTHPLACE OF FATHER (city or town) Bates
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary C. Rockey

13 BIRTHPLACE OF MOTHER (city or town) Bates
(State or country) Md.

14 Informant Theodore Apple
(Address) 906 Hanover St.

15 Filed AUG 2 1920, 19 G. H. Gross, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1920

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1920, to Aug. 1, 1920, that I last saw h— alive on Aug 1, 1920, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Spasmodic

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. L. Campbell M. D.

Aug 1, 1920 (Address) 1641 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	8/3 1920
20 UNDERTAKER J. J. Fahey & Sons	ADDRESS 318 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE OF DEATH is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D45314

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D45314

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 40 E. Clark St.; WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalia Pellizzio

(a) RESIDENCE. No. 40 E. Clark St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 4 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: ~~HUSBAND of~~ (or) ~~WIFE of~~ Husband

6 DATE OF BIRTH (month, day, and year): Feb 1 1920

7 AGE: Years 0 Months 6 Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Carmelo Pellizzio

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Angela Polonetta

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Carmelo Pellizzio (Address) 40 E. Clark St.

15 Filed AUG 2 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 1st 1920

17 I HEREBY CERTIFY, That I attended deceased from July 29 1920, to July 31st 1920, that I last saw h[illegible] alive on July 31st 1920, and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) J Wenderoth M. D.

(Address) 165 Aisquith 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	8/2 1920
20 UNDERTAKER	ADDRESS
Jas J. Gahagan	131 S. Gay St.

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Blks.

045315

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 045315

CERTIFICATE OF DEATH.

104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 306 S Chester ST.; 2 WARD)

2-FULL NAME Doris M Mahoney

(a) RESIDENCE. NO. 306 S Chester ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 30 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Mahoney

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Monika Zenco

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Monika Mahoney
(Address) 306 S Chester

15 Filed ..., 19... Registrar

AUG 2 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2nd 1920

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1920, to Aug 2, 1920, that I last saw her alive on Aug 2, 1920, and that death occurred, on the date stated above, at 2-30 a.m.

The CAUSE OF DEATH* was as follows:

aut Justa Intuste

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Wenton, M. D.

Aug 2, 1920 (Address) 16 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Aug 3 1920

20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

845316

845316

CERTIFICATE OF DEATH.

REGISTERED NO. C 63

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 936 Warner ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Powell

(Residence in Baltimore: No. 936 Warner St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, un Known (Month) (Day), 1894 (Year)

7-AGE, 26 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 03

9-BIRTHPLACE, (State or Country), Va,

PARENTS.

10-NAME OF FATHER, Evans MacKlin

11-BIRTHPLACE OF FATHER (State or Country), Va,

12-MAIDEN NAME OF MOTHER un Known

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Powell

(Address) 936 warner

15-

Filed AUG 2 1920, 191 G. H. Grese Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 1 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 19 1920, to Aug 1 1920, that I saw h[er] alive on July 31 1920, and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Acute Myelitis

(Duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. S. McCarl M. D.

8/2, 1920. (Address) 2005 Hillen

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bracey Va

DATE OF BURIAL, Aug 2, 1920

20-UNDERTAKER Wm Geo H Hooper

ADDRESS 416 Conway st

CAUSE OF DEATH to be plainly written. Every question must be answered if possible. Omissions cause delay and are important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

245817 HEALTH DEPARTMENT—CITY OF BALTIMORE 245817

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 14th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Schultz

(a) RESIDENCE. NO. 218 S Eutaw St Baltimore Md WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child - at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joe Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Catherine Schlichte

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. H. Hospital Records

15 Filed AUG 2 1920 G. H. Cr... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31st 1920

17

I HEREBY CERTIFY, That I attended deceased from July 21 1920, to July 31 1920,

that I last saw him alive on July 31 1920

and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harold L. Higgins, M. D.

7/1, 1920 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	aug 2 1920
20 UNDERTAKER	**ADDRESS**
John Grebliauckas	425 S. Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement required. See instructions on back of certificates. TION is very important.

245318 HEALTH DEPARTMENT—CITY OF BALTIMORE 245318

CERTIFICATE OF DEATH. 1920

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. May Hospital, ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip Jones

(Residence in Baltimore: No. 725 N. Calvert St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M | 4-COLOR OR RACE, W. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Married

6-DATE OF BIRTH, Jan 9- 1863 (Month) (Day) (Year)

7-AGE 57 yrs. 6 mos. 1 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tailor
(b) General nature of industry, business, or establishment In which employed (or employer)..... "

9-BIRTHPLACE, (State or Country) Greater England

PARENTS.
10-NAME OF FATHER James Jones
11-BIRTHPLACE OF FATHER (State or Country), England
12-MAIDEN NAME OF MOTHER Elizabeth Hill
13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Jones

(Address) 725 N. Calvert

15- AUG 2 1920 Filed....., 191..... G. H. Grese. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7 / 31 / 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ds. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol Wound of head (Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock (Duration) yrs. mos. ds.

(Signed) Geo. L. Blades M. D. (Coroner.)

7/31/20 (Address) 1432 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Trinity Cem. | DATE OF BURIAL, Aug 4, 1920

20-UNDERTAKER Wm. Cole & Co. | ADDRESS 502 E. Nork Ave

N. B.—Every item of information must be given, and care taken that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45319

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D45319

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Linsor ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Jesse E. Harden

(a) RESIDENCE. No. 1717 Linsor Av ST., 9 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Harden

6 DATE OF BIRTH (month, day, and year) July 12/1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist - 31

(b) General nature of industry, business, or establishment in which employed (or employer) Bartlett Hayward Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER John H. Harden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fowden Co Ga

12 MAIDEN NAME OF MOTHER Mary E. Grimes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Woodstock Md

14 Informant Anna Harden
(Address) 1717 Linsor

15 Filed AUG 2 1920 19 G. H. Greer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31st 1920

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1920, to July 31, 1920, that I last saw him alive on July 30, 1920, and that death occurred, on the date stated above, at 6.00 a m.

The CAUSE OF DEATH* was as follows:

Chr Endocarditis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute arthritis rheumatism (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr Bernard Lyons M. D.

. 19 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 3 1920
20 UNDERTAKER Wm Cook	ADDRESS 14 E Biddle

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45320

CERTIFICATE OF DEATH.

10 D45320

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 S Montford Ave. St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Leonard Eggert

(Residence in Baltimore: No. 819 S. Montford Ave. St.; ...yrs., 4 mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Single

6-DATE OF BIRTH, September 3, 1919
(Month) (Day) (Year)

7-AGE, ...yrs. 11 mos. ...ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ...None
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Eggert.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Rose Pruchniska

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Eggert.

(Address) 819 S. Montford Ave

15-

Filed 10 2 1920 191... C. H. Grese.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 1st, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 28 1920, to Aug 1 1920, that I saw him alive on July 31 1920, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

(a) Gastro - Enteritis

(Duration) ...yrs. ...mos. 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ...yrs. ...mos. ...ds.

(Signed) C. Dunn M. D.

8/11/20, 191... (Address) 401 Dodon Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem — DATE OF BURIAL, Aug 2, 1920

20-UNDERTAKER Jas. C. Miller — ADDRESS 2534 Jeffson

Physician will please fill in items 1 to 18 as far as may be practicable. Items 16 to 18 are important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D45321

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45321

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 538 N Caroline St.; 16 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J Hynes

(Residence in Baltimore: No. 538 N Caroline St.; 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Oct. 15, 1850. (Month) (Day) (Year)

7-AGE. 69 yrs. 9 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. Joshua Hynes

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Rebecca Howe

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs John J Hynes

(Address) 538 N Caroline St

15-

Filed AUG 2 1920, 191.. G. H. Gross Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 30, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 7 1919, to July 28 1920, that I saw h[illegible] alive on July 28 1920, and that death occurred, on the date stated above, at 6 30 A. m.

The CAUSE OF DEATH* was as follows: Cerebral Embolism

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Epithelioma (Right Ear)

(Duration) 18 yrs. mos. ds.

(Signed) James A. Fordyce M. D.

July 31, 1920. (Address) 1722 E Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park. DATE OF BURIAL, Aug 2, 1920.

20-UNDERTAKER Harry H Nitzke ADDRESS 103 N Fremont St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45322

CERTIFICATE OF DEATH.

120 D 45322

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 39 E. Pulaski St.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Winifred Cousins

(Residence in Baltimore: No. 39 E. Pulaski St.; yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Dec 23, 1879 (Month) (Day) (Year)

7-AGE. 40 yrs. 7 mos. 8 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. House Wife (b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER. Andrew Doyle

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Mary Lloyd

13-BIRTHPLACE OF MOTHER (State or Country) Elizabeth Hilded

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Albert W. Cousins

(Address). 39 E. Pulaski St

15- G. H. Gresz

Filed AUG 2 1920, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 31st, 1920. (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from July 30 1920, to July 31 1920, that I saw her alive on July 31 1920, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Duration yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Nephritis Chronic 30 mos.

Duration yrs. mos. ds.

(Signed) C. K. Nuckols M. D.

July 31, 1920 (Address) 130 E. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery

DATE OF BURIAL, Aug 3, 1920

20-UNDERTAKER Harry H. Nitzsche

ADDRESS 1031 W. Lombard St

CAUSE OF DEATH must be plainly written and important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45 323 — 1500 — D 45323

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 39 S. Pulaski ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert F. Cousins

(Residence in Baltimore: No. 39 S. Pulaski St.; Life yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write word.)

6-DATE OF BIRTH, July 30 —, 1920
(Month) (Day) (Year)

7-AGE, — — — yrs. mos. da. If LESS than 1 day, 11 hrs. or — min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) 39 S. Pulaski St

PARENTS.

10-NAME OF FATHER, Albert. M. Cousins

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Agnes Winfred Doyle

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert F. Cousins

(Address) 39 S. Pulaski

15- Filed AUG 3 1920 191.....
G. H. Gress
Registrar.

CAUSE OF DEATH must be filled in. See instructions on back of certificate. important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 31, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 30 1920, to July 31 1920, that I saw him alive on July 30 1920, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Congenital
Heart disease

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) C. F. Nuchols M. D.

July 31, 1920 (Address) 130 S. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cemetery	Aug. 3, 1920.
20-UNDERTAKER Harry S. Nitzsche	ADDRESS 1531 W. Fayette St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45328 HEALTH DEPARTMENT—CITY OF BALTIMORE D45328

CERTIFICATE OF DEATH.

REGISTERED NO. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 Brunt ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. D Longenfelder

(a) RESIDENCE. No. 1813 Brunt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs 44 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Wh	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 6/19

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Chas. Longenfelder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Lillian Poulsen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Chas. Longenfelder (Address) 1813 Brunt st

15 Filed AUG 2 1920 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1920

17 I HEREBY CERTIFY, That I attended deceased from July 30 1920, to Aug 1 1920, that I last saw h.. alive on Aug 1 1920, and that death occurred, on the date stated above, at 2.45 a m.

The CAUSE OF DEATH* was as follows:

Enteritis, (always delicate)
* Teething

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Convulsions 6 hrs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Death

(Signed) Ed Smith, M. D.

(Address) 1600 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudenwork.	Aug 2 1920

20 UNDERTAKER Josiah Lyson ADDRESS 1600 W North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D45328 HEALTH DEPARTMENT—CITY OF BALTIMORE D45325

CERTIFICATE OF DEATH.

104

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1001 Penn. Ave. ST.: 17 WARD)

(If death occurred in a hospital or institution give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Willis Nathaniel

(Residence in Baltimore: No. 1001 Penn. Ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.)
M	C	Single

6-DATE OF BIRTH, Apr 2, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work — —
(b) General nature of industry, business, or establishment in which employed (or employer) — Child.

9-BIRTHPLACE, (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER, Robt Turner

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Mollie Nathaniel

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mollie Nathaniel

(Address) 1001 Penna Ave.

15-

Filed ....., 1920 191.... C. H. Cress Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8/1/20 1 30 PM.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ....yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 1 ds.

(Signed) Louis Blades M. D.
(Coroner.)

8/1/20, 191... (Address) 1436 Bway.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem.	Aug 2, 1920
20-UNDERTAKER Samuel T. Hemsley	ADDRESS 578 W Fidde

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45326

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45326

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2424 Jefferson ST.: 7 WARD)

2-FULL NAME Edith M. Cooper

(a) RESIDENCE. No. 2424 E. Madison ST., ..WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 11 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of: Clarence A. Cooper

6 DATE OF BIRTH (month, day, and year): Aug. 27/1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-work

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: James A. Roper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Lavina —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Clarence A. Cooper
(Address) 2424 Jefferson St.

15 Filed AUG 2 1920 19 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31st 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1 1920 to July 31 1920

That I last saw h... alive on July 31 1920

and that death occurred, on the date stated above, at 3:10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Intercostal

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Kearney M. D.

8/1 1920 (Address) 413 N. Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Aug 3rd 1920
20 UNDERTAKER: Philip Herwig	ADDRESS 2016 Orleans St.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45327 HEALTH DEPARTMENT—CITY OF BALTIMORE D45327

CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2411 Jefferson St.: 7 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Stein

(a) RESIDENCE. No. 2411 Jefferson St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs 4 mos. 16 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)

5a ~~If married, widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Catherine Stein

6 DATE OF BIRTH (month, day, and year) Mar. 14/1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watch-man 067

(b) General nature of industry, business, or establishment in which employed (or employer): Clothing

(c) Name of employer: Schloss Bros - Balto Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Catherine Stein
(Address) 2411 Jefferson St -

15 Filed AUG 2 . 1920 G. H. Grese, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30th 1920

I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to July 30, 1920, that I last saw h~~im~~ alive on July 30, 1920, and that death occurred, on the date stated above, at 6P m.

The CAUSE OF DEATH* was as follows:

carcinoma of stomach & liver

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) myocarditis.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical + mass

(Signed) I Frederick Lantz, M. D.

8/1, 1920 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 2 1920
20 UNDERTAKER	ADDRESS
Philip Herwig	2016 Orleans St

CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

245328

CERTIFICATE OF DEATH.

79 245328

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2820 E. Madison ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie E. Robinson

(a) RESIDENCE. No. 2820 E. Madison ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Joseph L. Robinson

6 DATE OF BIRTH (month, day, and year) Sept. 29/1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER August Woerner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret L.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Joseph L. Robinson (Address) 2820 Jefferson St.

15 Filed AUG 2 1920 G. H. Grese, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30th 1920

17 I HEREBY CERTIFY, That I attended deceased from May 21 1920, to July 30 1920, that I last saw h[illegible] alive on July 30 1920, and that death occurred, on the date stated above, at 4-20 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Conrad Schmidt, M. D.

, 19 (Address) 701 N. Kenwood ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ind. Carmel Cem.	Aug 2nd 1920
20 UNDERTAKER Philip Hennig	ADDRESS 2016 Orleans St

CAUSE OF DEATH. TION is very important. See instructions on back of certificates.

D45329

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C 1572 D45329

CITY OF BALTIMORE: (No. 1805 N. Port St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Estelle Hubert-

(Residence in Baltimore: No. 805 N Port St St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	white	Single

6-DATE OF BIRTH July (Month) 17 (Day), 1920 (Year)

7-AGE ... yrs. ... mos. 15 ds. If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: John F Hubert

11-BIRTHPLACE OF FATHER (State or country): Balto Md

12-MAIDEN NAME OF MOTHER: Estelle M Weinman

13-BIRTHPLACE OF MOTHER (State or country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Hubert

(Address) 1805 N Port St

15-

Filed 1920 G. H. Grace REGISTRAR

A008

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH August (Month) 1 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 31, 1920, to, August 1 1920, that I saw h er alive on aug 1 1920, and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

Child 7 months premature
Wt 2 lbs at birth

Atelectasis

(Duration) ... yrs ... mos 1/2 ds.

Contributory (SECONDARY) ...

(Duration) ... yrs ... mos. ... ds.

(Signed) Thos Fa Steeves M. D.

Aug 1 1920 [Address] 1866 Hanford St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 8/2/1920

20-UNDERTAKER: J. J Mora

ADDRESS 1000 E Baltimore

state CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 2045330

CERTIFICATE OF DEATH.

150 D 2045330

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 505 h. Streeper ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Davidson

(a) RESIDENCE. No. 505 N. Streeper ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): July 27th 1920

7 AGE: Years | Months | Days: 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Fredrick Davidson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Elizabeth Davidson (Address) 505 N. Streeper

15 Filed AUG 2 1920 G. H. Grace Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30 1920

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1920, to July 30, 1920, that I last saw h[illegible] alive on " " 1920, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Failure of Heart to Close (Blue Baby)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. C. Hagen M. D.

7/31, 1920 (Address) 76 or E Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: 8/4/1920

20 UNDERTAKER: J. G. Moran — ADDRESS 30 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45331 D45331

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1111 N Carey ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice Baddy

(a) RESIDENCE. NO. 1111 N Carey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10. 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady's maid

(b) General nature of industry, business, or establishment in which employed (or employer): Attendg lady

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Canonsburg Md

PARENTS

10 NAME OF FATHER: Reuben Baddy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Canonsburg Md

12 MAIDEN NAME OF MOTHER: Annie Boyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Canonsburg Md

14 Informant: Estelle Bigham

(Address) 1111 N. Carey St

15 Filed AUG 9 1920 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1920, to July 31, 1920, that I last saw h alive on July 31, 1920, and that death occurred, on the date stated above, at 10:45 m.

The CAUSE OF DEATH* was as follows:

Nephritis (Bright Disease)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. Gardy Shipley M. D.

Aug 2 1920 (Address) 1534 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Canonsburg Cribbons	Aug 3 1920

20 UNDERTAKER: George H. Holland ADDRESS: 1631 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be understood by the people. See instructions on back of certificates. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D45332 HEALTH DEPARTMENT—CITY OF BALTIMORE D45332

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 800 Belgian Ave. ST.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. L. Fehm

(a) RESIDENCE. No. 800 Belgian Ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 25 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	5	31	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jos. M. J. Fehm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Faher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Jos. J. Fehm Jr. 800 Belgian Ave

15 Filed AUG 2 1920 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

17 I HEREBY CERTIFY, That I attended deceased from May 1 1920 to July 31 1920 that I last saw h[illegible] alive on July 30 1920 and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In Service in France

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H C Fehm, M. D.

[illegible]-7, 1920 (Address) r 800 York Rd Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Govans	Aug 3 1920
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	918 Greenmount

CAUSE OF DEATH must be plainly written. Use ink. Do not use abbreviations or ditto marks. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45333

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45333

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary A. Steinmeier

(a) RESIDENCE. No. 1118 Brentwood ST. Ave WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mr. Geo. Steinmeier

6 DATE OF BIRTH (month, day, and year) Aug 15 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. ... min.
	52	~~Aug 15~~	~~1867~~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... 37

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thos. Mooney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland (Is not known)

12 MAIDEN NAME OF MOTHER Kath. Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md (Is not known)

14 Informant Miss Marie Steinmeier
(Address) 1118 Brentwood Ave.

15 Filed ... 19 ...
AUG 2 1920 G. H. Greer. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31 1920

17 I HEREBY CERTIFY, That I attended deceased from 7-11- 1920, to 7-31, 1920

that I last saw h[illegible] alive on 7-21, 1920

and that death occurred, on the date stated above, at 5.50 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus - Chr.
Nephritis - Hypertension -
Glandular & Pulmonary Tuberculosis (duration) ... yrs. 8 mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation - Pulmonary Edema. (duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Chemical, Microscopic and X-Ray.

(Signed) W. C. Caldwell M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Aug 4 192[illegible]
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Greenmt Ave

CAUSE OF DEATH. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45 334

CERTIFICATE OF DEATH.

120 D45334

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2825. N. Calvert St.: 17 WARD)

2-FULL NAME Frank Henry Ewald

(a) RESIDENCE. No. 2825 N. Calvert St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs 8 mos. ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Cora L. V. Ewald

6 DATE OF BIRTH (month, day, and year) March 2nd 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief clerk U. M. C. 6-9

(b) General nature of industry, business, or establishment in which employed (or employer) U. M. C.

(c) Name of employer United States Govt.

9 BIRTHPLACE (city or town) (State or country) Hoboken N. J.

PARENTS

10 NAME OF FATHER William Ewald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minna Benza

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Cora L. V. Ewald 2825 N. Calvert St.

15 Filed AUG 2 1920 19.... G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31st 1920

I HEREBY CERTIFY, That I attended deceased from June 19th 1920, to July 31st 1920

that I last saw him alive on July 31st 1920

and that death occurred, on the date stated above, at 7.30 P.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
(Hypertension)
Not Known (duration) — yrs. — mos. — ds.
Uremic Coma —

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? By pertinacious albumen + Casts

(Signed) Frederick D. Owen M. D.

, 19 (Address) 2827 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooklyn N. Y.

DATE OF BURIAL aug 5th 1920

20 UNDERTAKER Graham F. Wasden & Co

ADDRESS 723 Cathedral

CAUSE OF DEATH in plain terms, so that it may be properly classified. Only one cause under each number. Omit modes of dying. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45335

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45335

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 5 WARD) 25

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Johnson

(a) RESIDENCE. No. 312 N. Eden St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: City in Balt 20 years

9 BIRTHPLACE (city or town) (State or country): Wilmington, Delaware

PARENTS

10 NAME OF FATHER George Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wilmington, Del.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wilmington, Delaware

14 Informant: Hospital Records, (Address) New City Hospital

15 Filed AUG 2 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31, 1920

17

I HEREBY CERTIFY, That I attended deceased from June 30, 1920, to July 31, 1920

that I last saw him alive on July 31, 1920

and that death occurred, on the date stated above, at 9:15 A. m.

The CAUSE OF DEATH* was as follows:

Blastomycosis.

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Amyloidosis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) H. Herman M. D.

7-31-20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Aug 3 1920
20 UNDERTAKER	ADDRESS
Wm R A Elliott	Wilmington Del

CAUSE OF DEATH in plain terms. Indefinite or unsatisfactory answers will not be accepted. ATTENDING PHYSICIAN'S SIGNATURE AND ADDRESS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45336

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45336

1-092

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2444 Buchanan (St.) 17 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Poe

(a) RESIDENCE. No. 2444 Buchanan St.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE — Years 16 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Bar Boy
(b) General nature of industry, business, or establishment in which employed (or employer): Shipping office
(c) Name of employer: Emergency Hotel, Lombard in Baltimore

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Allen Poe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Allen Poe
(Address) 2444 Buchanan St

15 Filed AUG 2 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) July 31 1920

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1920, to July 31, 1920.
that I last saw him alive on July 31, 1920
and that death occurred, on the date stated above, at 4 a. m.
The CAUSE OF DEATH* was as follows:

(a) Typhoid fever (?)

Duration yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typhoid Eberthella

(Signed) R. Garland Thomas, M. D.

(Address) 1534 E. H. Ave Aug 2 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Aug 3 1920
20 UNDERTAKER: Mrs R. A. Elliott	ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45337 HEALTH DEPARTMENT—CITY OF BALTIMORE D45337

CERTIFICATE OF DEATH. 104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 Kavanaugh ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olive Burton

(a) RESIDENCE. No. 1819 Kavanaugh ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ~~Aug 23 19~~

6 DATE OF BIRTH (month, day, and year) Aug 23 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) ~~God~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city

PARENTS

10 NAME OF FATHER Edward Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Lena

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Edward Burton
(Address) 1819 Kavanaugh St

15 Filed AUG 2 1920 J. H. Greer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1920, to July 31, 1920, that I last saw h~~i~~m alive on July 30, 1920, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute Pleurolitis

3 wks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

4 days (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Edward Fisher, M. D.

8-1 1920 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters.	AUG -2 1920

20 UNDERTAKER JAMES H. DENNIS — ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. ALL QUESTIONS must be answered if possible. DATE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45338 — 104 — D 45338

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1028 Pennington Ave ST.: Curtis Bay (WARD) 25

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary H. Trhlik.

(a) RESIDENCE. NO. 1028 Pennington Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 10 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16th 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Curtis Bay, Md.

PARENTS

10 NAME OF FATHER Englbert Trhlik.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia.

12 MAIDEN NAME OF MOTHER Mary Hrubek.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia.

14 Informant (Address) Englbert Trhlik 1028 Pennington Ave.

15 Filed AUG 2 1920 C. H. Gre... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31st 1920

17 I HEREBY CERTIFY That I attended deceased from July 31st 1920, to July 31st 1920, that I last saw her alive on July 31st 1920, and that death occurred, on the date stated above, at 3-P. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) yrs. 15 Min.

CONTRIBUTORY (Secondary) Indigestion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thos. B. Horton, M. D.

, 19 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. Balto. Co.	Aug 2, 1920
20 UNDERTAKER	ADDRESS
Margaret V. Flynn	1422 Light St

CAUSES OF DEATH ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45339 — 104 — D45339

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1038 Sharp ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Donald Fleece

(Residence in Baltimore: No. 1038 Sharp St.; ...yrs., 3 mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov. 5th, 1919
(Month) (Day) (Year)

7-AGE, ...yrs. 8 mos. 27 ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): Dead

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Harry Fleece

11-BIRTHPLACE OF FATHER (State or Country), W. Va.

12-MAIDEN NAME OF MOTHER Sadie Metz

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Fleece

(Address) 1038 E. Sharp St.

15-

Filed AUG 2 1920 ... Registrar. G. H. Gue

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 1st, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1, 1920, to Aug 1, 1920, that I saw him alive on Aug 1, 1920, and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis

(Duration) ...yrs. ...mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) ...yrs. ...mos. 3 hrs.

(Signed) Leo L. Davis M. D.

Aug 2, 1920 (Address) 711 Chapel St. Little Italy

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Alto Pa

DATE OF BURIAL, Aug. 4, 1920

20-UNDERTAKER M. St. Flynn

ADDRESS 1421 Light St.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D45340

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D45340

CERTIFICATE OF DEATH.

REGISTERED NO. C 1047

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 Emory ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Kimball Morgan

(Residence in Baltimore: No. 216 Emory St St.; ....yrs.. ....mos. ....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	Black	Single

6-DATE OF BIRTH, August 9, 1920
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs. 9 mos. ....da.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, George Morgan

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Goldie Mashman.

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Morgan

(Address) 216 Emory St.

15-

Filed AUG 2 1920 G. H. Gress
Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 1, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1920, to July 31 1920, that I saw h[illegible] alive on July 31 1920, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:—

Gastro-Enteritis

(Duration) ....yrs. 1 mos. ....da.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. 1 mos. ....da.

(Signed) H. Adler M. D.

....., 191... (Address) 1919 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Sinai Park Co	Aug. 3..., 1920
20-UNDERTAKER	ADDRESS
H. L. Parham	1314 Walnut

D45341 HEALTH DEPARTMENT---CITY OF BALTIMORE D45341

CERTIFICATE OF DEATH

104

1 PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 3313 Edmondson ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E Simmons

(Residence in Baltimore: No. 3313 Edmondson ave St.; yrs. 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6-DATE OF BIRTH: Nov (Month) 3 (Day), 1920 (Year)

7-AGE: yrs. 9 mos. 27 ds. — If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Balto Md.

PARENTS

10-NAME OF FATHER: Robert B Simmons

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Ida F Westphal

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert B Simmons

(Address) 3313 Edmondson

15-

Filed AUG 2 1920 C. H. Grese. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: August (Month) 1 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 31, 1920, to, Aug 1 1920, that I saw him alive on [redacted] Aug 1 1920, and that death occurred, on the date stated above, at 5h a m.

The CAUSE OF DEATH* was as follows:

Acute Gastro enteritis

(Duration) yrs mos. 1 ds.

Contributory (SECONDARY)

(Duration) yrs mos. ds.

(Signed), Frank H. Hillis M D

Aug 1 1920 [Address] 2838 Edmondson Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Johns cemetery Govans Md — DATE OF BURIAL: Aug 3 1920

20-UNDERTAKER: W M Rankin — ADDRESS: 2238 W North Ave

state CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D45342

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45342

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23 N Fulton Ave ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan Tedley

(Residence in Baltimore: No. 23 N Fulton Ave St.; ....yrs....mos....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, October (Month) 9 (Day), 1856 (Year)

7-AGE, 63 yrs. 9 mos. 10 da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... D

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Parker

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Tedley

(Address) 23 N Fulton Ave

15-

Filed....., 191.... G. H. Grese. Registrar.

AUG 9 1920

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 31 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 1920, to July 31 1920, that I saw her alive on July 31 1920, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Nephritis parenchymatous

(Duration) yrs. 6 mos. ....da.

CONTRIBUTORY (Secondary) Ascites

(Duration) yrs. 2 mos. ....da.

(Signed) A. H. A. Meyer M. D.

VIII. 6, 1920 (Address) 2438 Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL, Aug 2, 1920

20-UNDERTAKER Robert Brokenborough ADDRESS 178 Calhoun St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45343 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D45343

CERTIFICATE OF DEATH. 105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Lancaster St.: W Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jozefa Fidrych

(a) RESIDENCE. No. 1102 Lancaster St., W Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	W.	Married

5a If married, widowed or divorced
HUSBAND of (or) WIFE of Frank Fidrych

6 DATE OF BIRTH (month, day, and year) March - 1889.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Antoni Marzlewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Eva Wrzykowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant W. F. Sadowski.
(Address) 705 S. Ann St

15 Filed AUG 2 1920 19 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 19 20

17 I HEREBY CERTIFY, That I attended deceased from July 31, 19 20, to Aug 1, 19 20, that I last saw h... alive on 2 P.M. July 31, 19 20, and that death occurred, on the date stated above, at 8 A.M. m.

The CAUSE OF DEATH was as follows:

Uraemia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical diagnosis

(Signed) W. D. Wheaton, M. D.

19 (Address) 500 Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	Aug 4 1920

20 UNDERTAKER W. F. Sadowski. ADDRESS 705 S. Ann

CAUSE OF DEATH must be plainly written, and all questions answered. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D45344

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D45344

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 N. Stricker St, ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Craddock

(Residence in Baltimore: No. 504 N. Stricker St. St.; yrs., 5 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F 1	Colored	

6-DATE OF BIRTH, March (Month), (Day), 1920 (Year)

7-AGE, yrs. 5 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Richard Craddock

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Myrtle Patterson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Craddock

(Address) 504 N. Stricker St

15. Filed AUG 2 1920, 19.., C. H. Grese. Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 31 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1920, to July 29 1920, that I saw h[illegible] alive on July 29 1920, and that death occurred, on the date stated above, at 4.00 p.m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

..... (Duration)....yrs....mos....5....ds.

CONTRIBUTORY (Secondary) Malnutrition

..... (Duration)....yrs....2....mos....ds.

(Signed) Howard H. W. Armer M. D.

Aug. 2, 1920 (Address) 2604 Garrison Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 5 yrs. 5 mos. 2 ds. In the State yrs. 5 mos. 2 ds.

Where was disease contracted, if not at place of death? 504 N. Stricker St

Former or usual residence 504 N. Stricker St

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn August 2, 1920

DATE OF BURIAL,

20-UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45345 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D.45345

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bradley

(a) RESIDENCE. NO. 915 McCulloh St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Wm. T. Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER Mary Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Iowa

14 Informant Hospital Records (Address) M.T.H.

15 Filed AUG 2 1920 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1920

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1920, to July 28, 1920, that I last saw him alive on July 28, 1920, and that death occurred, on the date stated above, at 5 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. 6 weeks mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum.

(Signed) L. J. Rigney, M. D.

7-29-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL AUG 3 1920 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health,

per Wm. H. W[illegible]

CAUSE OF DEATH to be plainly written. TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45346

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45346

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 W Fayette ST.: 4 WARD)

REGISTERED NO. 1042

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur G. Monty

(a) RESIDENCE. No. 722 W Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 17/1919

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Geo. A Monty

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y. N.Y.

12 MAIDEN NAME OF MOTHER Flora S. Webber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Geo A. Monty

(Address) 722 W Fayette

15 Filed AUG 2 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH to be filled in plain terms, so that a non-medical person can understand it. See instructions on back of certificates. DIAGNOSIS OR CONDITION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1920

17

I HEREBY CERTIFY, That I attended deceased from July 25, 1920, to Aug 1, 1920, that I last saw him alive on Aug 1, 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. L. Campbell, M. D.

Aug 2 1920 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Aug 2 1920

20 UNDERTAKER Robert Brockerson ADDRESS 8 Calhoun

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.45347

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45347

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 1005 Argyle ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Joseph D Aquilla~~ Aquilla

(a) RESIDENCE. NO. 1005 Argyle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence is city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colord	Marid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arville Aquilla

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 59				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edward Aquilla

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant (Address) Amelia Aquilla 1005 Argyle Ave

15 Filed AUG 2 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1920, to July 31, 1920, that I last saw h alive on July 29, 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cancer Oesophagus

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Chronic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X Ray yes

(Signed) James L Hobbs, M. D.

, 19 (Address) 346 E 28 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount auburn	aug 3 1920
20 UNDERTAKER John H Owens	ADDRESS 5-38 Dolphin

CAUSE OF DEATH in plain terms, and TION is very important. See instructions on back of certificates.

D.45348 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45348

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1826 Belt Ave. ST.: 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin Nagle.

(Residence in Baltimore: No. 1826 Belt Ave. St.) yrs., 7 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, December 24th. 1919, (Month) (Day) / (Year)

7-AGE, ---yrs. 7 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, George Nagle.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Lillian Brooks.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian Nagle(mother)

(Address) 1826 Belt Ave.

15- AUG 2 1920 Dec'd ....., 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be understood. Omission of important facts may cause delay. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 1st. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cholera Infantum.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) H. M. Reinhardt (Coroner.) M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem	Aug 3rd 1920
20-UNDERTAKER	ADDRESS
John F Cowan & Son	901 Holliday St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 45349 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 45349

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 Parkin ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry C. Boswell.

(a) RESIDENCE. No. 30 Parkin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 31st. 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm. H. Boswell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Elsie Keeny.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Wm Boswell. (Address) 30 Parkin St.

15 Filed AUG 2 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2 1920.

17 I HEREBY CERTIFY, That I attended deceased from July 31. 1920. to Aug. 2. 1920. that I last saw him alive on Aug. 2. 1920. and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? none.

(Signed) J. Chas Norton, M. D.

8/2, 1920 (Address) 888 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem.	Aug 3rd 1920
20 UNDERTAKER John J. Cowan & Son.	ADDRESS 901 Halbert St

CAUSE OF DEATH must be given in plain English. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.45350 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.45350

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1632 Clarkson ST.: 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Kenneth Grail

(a) RESIDENCE. NO. 1632 Clarkson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 4 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Chas. E. Grail

11 BIRTHPLACE OF FATHER (city or town) Port Deposit
(State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Rehn

13 BIRTHPLACE OF MOTHER (city or town) Balto.,
(State or country) Md.

14 Informant Chas. E. Grail
(Address) 1632 Clarkson St.

Filed AUG 2 1920 Robert P. Harrison
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1920, to July 31, 1920
that I last saw h alive on July 31, 1920
and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:
Acute Gastro Enteritis

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) H. E. T. Campbell M. D.

Aug. 2, 1920 (Address) 1644 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Aug. 3 1920
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1422 Eutaw St.

CAUSE OF DEATH must be stated plainly. See instructions on back of certificate. TION is very important.

Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45351 HEALTH DEPARTMENT—CITY OF BALTIMORE D45351

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Sanders

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records. (Address) New City Hospital

15 Filed AUG 2 1920 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1920

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1912 to July 30, 1920 that I last saw h er alive on July 30, 1920 and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis (no cerebral hemorrhage)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Idyocardial insufficiency (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test

(Signed) [illegible], M. D.

7/31/1920 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cem

DATE OF BURIAL Aug. 3 1920

20 UNDERTAKER M. A. Flynn

ADDRESS 1428 Light

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

D.45352

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45352

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Railroad ave ST.; 25 WARD) 9044

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H Ridgway

(Residence in Baltimore: No. Rail Road ave nr Herman St.; ....yrs., 1 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, June (Month) 8 (Day), 1910 (Year)

7-AGE, 10 yrs. 1 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Richard Ridgway

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Olive O'Neill

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Ridgway

(Address) Nr Herman's

15- Robert P. Harrison,

AUG 2 1920

Dated....., 191.... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 2 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1920, to Aug 2 1920, that I saw him alive on Aug 1 1920, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea and Enteritis

(Duration) 10 yrs. 10 mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Raymond Stearns M. D.

Aug 2, 1920. (Address) Lakeland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Aug 3, 1920
20-UNDERTAKER	ADDRESS
George J Lilly	Fayette &

CAUSE OF DEATH must be stated in plain English. See instructions on back of certificate. important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.45353 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45353

64 V.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1300 N. Fr. Luzerne St. 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sabina Greenland

(a) RESIDENCE. No. 1300 N. Fr. Luzerne ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife of Joseph F. Greenland

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years: About 70 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Joseph Hostler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Lindsay

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant (Address): Joseph F. Greenland 1300 N. Fr. Luzerne

15 Filed AUG 2 1920. 19 Robert P. Harrison, Registrar

Dr Young Issued Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 2 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1 . 1920 . to July 2 . 1920 .

that I last saw h[illegible] alive on July 2 19 20

and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo Young, M. D.

. 19 (Address) 1500 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harrisburg Pennsylvania | DATE OF BURIAL: Aug 3rd 1920

20 UNDERTAKER: Williams Cook | ADDRESS: 502 E Wath

CAUSE OF DEATH TION is very important. See instructions on back of certificate.

D.45354

HEALTH DEPARTMENT—CITY OF BALTIMORE. D.45354

CERTIFICATE OF DEATH.

175-001

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mursity Hospital ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm E. Herbert Jr

(Residence in Baltimore: No. 1029 Brooks St

St.: yrs., 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ... Nov. (Month) 20 (Day), 1909 (Year)

7-AGE, 10 yrs. 8 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, W. E. Herbert

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Kate Mackey

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. E. Herbert

(Address) 1029 Brooks St

15-

Filed AUG 1920, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 31 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.....(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(Duration) ..... yrs. a few mins. mos. ds.

CONTRIBUTORY (Secondary) Struck by Automobile

(Duration) ..... yrs. a few mins. mos. ds.

(Signed) W. K. Gannett M. D.
(Coroner.)

8-2-20, 192.. (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cem	Aug 3rd, 1920
20-UNDERTAKER	ADDRESS
J. Schloman Son	1039 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45355

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45355

CERTIFICATE OF DEATH.

80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 Russell ST.; 21 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry L. Dienstbach

(Residence in Baltimore: No. 1004 Russell St.; 51 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ... Feb. (Month) ..... 5 (Day), 1869 (Year)

7-AGE.	If LESS than 1 day,
51 yrs. 5 mos. 26 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Shipping Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Phillip Dienstbach

11-BIRTHPLACE OF FATHER (State or Country). Germy

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katie B. Dienstbach

(Address) 1004 Russell st.

15- AUG 1920, 191.....

Robert P. Harrison,
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 1st (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 21 1920, to Aug 1 1920, that I saw him alive on Aug 1 1920, and that death occurred, on the date stated above, at 7:00 m.

The CAUSE OF DEATH* was as follows:

.....

.....

Angina Pectoris

(Duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robt. P. Schmidt M. D.

Aug 2, 1920 (Address) 1318 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Aug 4th, 1920

20-UNDERTAKER F. Schloman & Son — ADDRESS 1039 Hanover st

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45356 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45356

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophie Ruda

(Residence in Baltimore: No. 922 Shuter St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, Oct 5 1856
(Month) (Day) (Year)

7-AGE, 64 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work H.W. 37
(b) General nature of industry, business, or establishment in which employed (or employer) ....?

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Jos. Hetopes

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Ida Kohn

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane Rada

(Address) 922 Shuter St

15-

Filed 1920 Robert P. Harrison,
Registrar.

AUG 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 1st, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 23 191, to Aug 1st 1920, that I saw her alive on Aug 1st 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung metastasis to spleen,

(Duration) ....yrs. 4 mos. ....ds.

CONTRIBUTORY (Secondary) Myocard. degeneration

(Duration) ....yrs. ....mos. ....ds.

(Signed) Charles Lee, M. D.

....., 191... (Address) Hebrew Hosp'l

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Aug 3, 1920

20-UNDERTAKER Frank Evans & Son

ADDRESS 1906 Eastlake

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Rks.

D45357

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45357

CERTIFICATE OF DEATH.

108

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 E Federal St. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Kinson

(a) RESIDENCE. No. 218 E Federal St ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charleston D

6 DATE OF BIRTH (month, day, and year) [illegible] 188[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
35				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State of country) Charles Co Md

PARENTS

10 NAME OF FATHER Mathews Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co Md

12 MAIDEN NAME OF MOTHER Eliza Jamison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles Co Md

14 Informant George Mathews (Address) 829 Ashland Ave

15 Filed AUG 3 1920 Registrar C. H. Grese

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1920

17 I HEREBY CERTIFY, That I attended deceased from July 26th 1920, to July 31 1920.

That I last saw her alive on July 31st 1920.

and that death occurred, on the date stated above, at 1:00 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 4 yrs. 7 mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? No Date of 2nd

Was there an autopsy? No

What test confirmed diagnosis? Physical symptoms

(Signed) Chas F Wall, M. D.

, 19 (Address) 426 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: A Peters — DATE OF BURIAL: Aug 3 1920

20 UNDERTAKER: Samuel L Crumley — ADDRESS: 1718 N Bond

CAUSE OF DEATH to plainly written, or typewritten, and without abbreviation. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D45358 HEALTH DEPARTMENT—CITY OF BALTIMORE D45358

CERTIFICATE OF DEATH. 429

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 Robert ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Norman

(Residence in Baltimore: No. 512 Robert St St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, July (Month) 15 (Day), 1862 (Year)

7-AGE, 58 yrs. — mos. 18 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Pt

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, John Potts

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Addie Matthews

(Address) 512 Robert

15-

Filed AUG 3 1920 1920 G. H. Cress Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 2 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 29 1920, to Aug 2 1920, that I saw h Ex alive on Aug 1 1920, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Pt

Fenural Carcinomata

(Duration) 11m yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. S. McCard M. D.

8/2, 1920 (Address) 2005 Hillen

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Brandon Evergreen DATE OF BURIAL, Aug 5 1920

20-UNDERTAKER George H. Hellen ADDRESS 1631 Hillen Hillen

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45359

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45359

CERTIFICATE OF DEATH.

170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 Linden ST.: 11 WARD)

2-FULL NAME Nathaniel Ross

(a) RESIDENCE. NO. 1002 Linden ST., WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Shredder

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Delia Bolton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Phoebe B. Ross

(Address) 1002 Linden Ave

15 Filed AUG 3 1920 19 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2nd 1920

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1919, to Aug 2, 1920

that I last saw him alive on Aug 2, 1920

and that death occurred, on the date stated above, at 4:10 p. m.

The CAUSE OF DEATH* was as follows:

Brights disease.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edward J. Wheatley, M. D.

8/2 1920 Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jno D Anderson Cemetery	Aug 5 1920

20 UNDERTAKER	ADDRESS
George H. Holland	1631 Druid Hill Ave

CAUSE OF DEATH to be filled in plainly. See instructions on back of certificates. TION is very important.

D45360 HEALTH DEPARTMENT—CITY OF BALTIMORE D45360

CERTIFICATE OF DEATH.

151V

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1624 Caulk Alley 19 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Lloyd Milburn

(Residence in Baltimore: No. 1624 Caulk Alley St.; yrs., / mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
M	C	Single

6-DATE OF BIRTH, June 21, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 12 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ---
(b) General nature of industry, business, or establishment in which employed (or employer) ---

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER Louis Milburn

11-BIRTHPLACE OF FATHER (State or Country) St. Marys Co. Md.

12-MAIDEN NAME OF MOTHER Louise Sheppard

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Milburn

(Address) 1624 Caulk Alley

15-

Filed AUG 3 1920 191 G. H. Cresse
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 2, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Rickets.

(Duration) ....yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ....yrs. 1 mos. 4 ds.

(Signed) G. L. Blades M. D.
(Coroner)

8/2/20/191... (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ---

Former or usual residence ---

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Aug 3 1920
20-UNDERTAKER	ADDRESS
Jno F. Chase & Son	1400 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Give information as completely as important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45361 — 1042 D45361

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1062 W. Fayette ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doris Soaper

(Residence in Baltimore: No. 1062 W. Fayette St.; — yrs., 6 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Jan 18, 1920 (Month) (Day) (Year)

7-AGE, — yrs. 6 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Soaper

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Jennie M Elgin

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie M Soaper

(Address) 1062 W. Fayette

15-

Filed....., 191.....

AUG 3 1920 C. H. Gress Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 2 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 2 1920, to Aug 2 1920, that I saw her alive on Aug 2 1920, and that death occurred, on the date stated above, at 8:00 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) Probably 1 week

CONTRIBUTORY (Secondary) None

(Duration) — yrs. — mos. — ds.

(Signed) Henry C Eby M. D.

Aug 2, 1920. (Address) 1203 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem — DATE OF BURIAL, Aug 3, 1920

20-UNDERTAKER John C. Mitchell — ADDRESS 1701 W. Fayette

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45362 HEALTH DEPARTMENT—CITY OF BALTIMORE D45362

CERTIFICATE OF DEATH. REGISTERED NO. .....

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Mercy Hospital (ST.: 4 WARD)

2-FULL NAME Mrs Kate Cohn

(a) RESIDENCE. (No.) Upland, Howard Co. (ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21, 1879

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dalto. Md.

PARENTS

10 NAME OF FATHER Wm.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) Upland Balto Co Md

15 Filed AUG 3 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1920

17 I HEREBY CERTIFY, That I attended deceased from July 24 1920, to Aug 2 1920, that I last saw her alive on Aug. 2 1920, and that death occurred, on the date stated above, at 325 p m.

The CAUSE OF DEATH* was as follows: Embolism Cerebral

CONTRIBUTORY (Secondary) Chronic Endocarditis. (duration) yrs. 4 mos. 8 ds.

Unknown. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) I. O. Ridgely, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Upland Balto Co Md

DATE OF BURIAL 8/6 1920

20 UNDERTAKER: J. J. Young & Sons

ADDRESS 1018 Eutaw St

CAUSE OF DEATH must be plainly filled in, and all questions answered. Information is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45363

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45363

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital St.) (WARD) 16

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Frank Balzer

(a) RESIDENCE. No. 1038 N. Stricker St. Street WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Mary Balzer

6 DATE OF BIRTH (month, day, and year) — 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. min.
	42 yrs.	Do not know		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ditto

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " " "

12 MAIDEN NAME OF MOTHER " " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " " "

14 Informant Mary Balzer (Address) 1038 N. Stricker Street

15 Filed AUG 3 1920 C. H. Grose Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 - 1 1920

17 I HEREBY CERTIFY, That I attended deceased from 6-26, 1920, to 8-1, 1920

that I last saw him alive on 8-1, 1920

and that death occurred, on the date stated above, at 5:00 p. m.

The CAUSE OF DEATH* was as follows:

Exhaustion. Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver

Caused Hospital June 26 1920 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 1920

Was there an autopsy? yes.

What test confirmed diagnosis? Exploratory operation

(Signed) Jacob Lowenstein, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Aug 4 1920
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	827 W. Fifth Av

THIS IS very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

245364 HEALTH DEPARTMENT—CITY OF BALTIMORE. 5/91 245364

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital, Bay View ST.: 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Pedrick.

(a) RESIDENCE. NO. ? ST., WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ? 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter. 0/5

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Haltinfield N.J.

PARENTS

10 NAME OF FATHER John R. Pedrick

11 BIRTHPLACE OF FATHER (city or town) Camden (State or country) N.J.

12 MAIDEN NAME OF MOTHER Carrie Grubb.

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Hospital Records. (Address) City Hospital.

15 Filed AUG 3 1920, 19 G. H. Gies Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1, 1920.

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1920, to Aug. 1, 1920, that I last saw him alive on Aug. 1, 1920, and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis with residual hemiplegia (old cerebral thrombosis)

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) B B Norman, M. D.

19?? (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 3rd 1920

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, stating the disease, and not the mode of dying, such as heart failure, asthenia, etc. SPECIFIC NATURE OF DISEASE IS DESIRED. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45365 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45365

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Rogers and Dennon Aves ST.: 27 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Henry Carrick

(a) RESIDENCE. No. Rogers and Dennon Aves ST. 27 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town, where death occurred 45 yrs. ? mos. ? ds. How long in U. S., If of foreign birth? 72 yrs. 0 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary H. Carrick

6 DATE OF BIRTH (month, day, and year) July-29-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	72	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery.

(c) Name of employer General Wholesale Groc Co

9 BIRTHPLACE (city or town) Laurel

(State or country) Prince George Co. Md

PARENTS

10 NAME OF FATHER Amos Carrick

11 BIRTHPLACE OF FATHER (city or town) Laurel

(State or country) Prince George Co. Md

12 MAIDEN NAME OF MOTHER Mary Elizabeth Downs

13 BIRTHPLACE OF MOTHER (city or town) Laurel

(State or country) Prince George Co. Md

14 Informant Charles G. Carrick - (son)

(Address) Rogers & Dennon Aves.

15 Filed AUG 3 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug - 2 - 1920

17 I HEREBY CERTIFY, That I attended deceased from July 15 1920, to July 1 1920, that I last saw him alive on Aug 1st 1920, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralysis + Oedema Lungs (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Tom D Wells, M. D.

, 19 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Aug - 4th 1920

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM E. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be understood by the people, and not by physicians only. Information is desired as to the exact disease, not the mode of dying, such as heart failure, asthenia, etc. Indefinite and unsatisfactory terms will be returned for correction. Special attention is called to the importance of stating the contributory (secondary) cause of death, when such existed. Violent deaths must be reported to the Coroner. Deaths from contagious diseases must be reported to the Health Department. Physicians are requested to report cases of tuberculosis, cancer, and other diseases dangerous to the public health. Duplicate certificates may be procured, if desired, by paying fee. See instructions on back of certificates.

D 45366 HEALTH DEPARTMENT—CITY OF BALTIMORE 79 D 45366

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1033 Sara Ann ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Mij. Phillips

(Residence in Baltimore: No. 1033 Sara Ann St.) (36 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Femal

4-COLOR OR RACE, Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, unknown, 1884 (Month) (Day) (Year)

7-AGE, 37 yrs. mos. da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home 837

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Johnson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Phillips

(Address) 1033 Sara Ann St

15-

Filed AUG 3 1920 G. H. Grese. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 31, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

H. V.

(Duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Acute dilatation of heart (Duration) Sudden yrs. mos. da.

(Signed) James W. Penton M. D. (Coroner)

July 31 1920 (Address) 704 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Aug 2, 1920

20-UNDERTAKER Burns & Ireland

ADDRESS 114 W. Lanvale St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45367

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105 D 45367

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital, Bay ST.: Vic WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hicks

(a) RESIDENCE. No. 508 St. Paul ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced (or) WIFE of Andrew Hicks

6 DATE OF BIRTH (month, day, and year) ? 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER John Toll

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Hospital Records.
(Address) City Hospital, Bay View

15 Filed AUG 3 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31, 1920.

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1920, to July 31, 1920, that I last saw her alive on July 31, 1920, and that death occurred, on the date stated above, at 8 40 P.m.

The CAUSE OF DEATH* was as follows:

Colitis (non-specific)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy; Blood count.

(Signed) Wm Eckman, M. D.

July 31, 1920 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Cumberland Cemetery	Aug 3 1920
20 UNDERTAKER	ADDRESS
F. E. & B. Ryf	102 E. Monument St

CAUSE OF DEATH in plain terms. Indefinite and unsatisfactory answers will not be accepted. Consult the reverse side of this certificate. INFORMATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45368 64 V D45368

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1227 Ashland ave 10 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and all but No. 18.)

2-FULL NAME John J McDonnell

(Residence in Baltimore: No. 1227 Ashland ave St.; 5 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH, Aug 1, (Month) (Day) 1834 (Year)

7-AGE. 86 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Dan'l Kenny

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Dan'l Kenny

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Laura Mahon

(Address) 122 Ashland Ave

15-

Filed ....., 191.....

AUG 3 1920 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 1, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 30 191x, to Aug 1 1920, that I saw him alive on Aug 1 1920, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(Duration) 5 yrs. mos. ds.

(Signed) John J Nash M. D.

Aug 2 1920 (Address) 936 Monument E

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL. Aug 4, 1920

20-UNDERTAKER Robt J Turner Jr

ADDRESS 18 & N Bway

CAUSE OF DEATH must be stated plainly and accurately. Use no abbreviations. Do not state mode of dying, such as "Heart Failure," "Asthenia," "Exhaustion," "Convulsions," "Uremia," "Coma," without stating the primary disease or injury causing it. Indefinite or incomplete statements will be returned for correction. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 45369

HEALTH DEPARTMENT—CITY OF BALTIMORE

412 D-45369

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 1118 Linden Ave ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jasper E Bryant

(a) RESIDENCE. No. 1118 Linden Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maud Bryant

6 DATE OF BIRTH (month, day, and year) March 4/1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bartlett & Hayward Co

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Caleb L Bryant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ella J Lusby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Ella J Bryant
(Address) 1118 Linden Ave

15 Filed AUG 3 1920 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to Aug 2, 1920, that I last saw him alive on Aug 1- 1920 and that death occurred, on the date stated above, at 2 30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Apr. 1919

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Alex. M. Evans, M. D.

, 19 (Address) 1425 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sharp's Va	Aug 5 1920

20 UNDERTAKER Jno Cahoon & Natha ADDRESS

CAUSE OF DEATH to be plain terms, so that a non-medical person can understand it. See instructions on back of certificates. TION is very important.

845370 HEALTH DEPARTMENT—CITY OF BALTIMORE 845370

CERTIFICATE OF DEATH. + 167 V

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Johns Hopkins Hospital ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Elvery L.Smith

(Residence in Baltimore: No. 702 East E.St.Sparrows Pt.Md. St.; yrs., mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, October (Month) 17 (Day), 1914 (Year)

7-AGE, 5 yrs. 10 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Sparrows Point Md.

PARENTS.

10-NAME OF FATHER, Charles H.Smith

11-BIRTHPLACE OF FATHER (State or Country). Lynchburg Va.

12-MAIDEN NAME OF MOTHER Hattie D.Sands

13-BIRTHPLACE OF MOTHER (State or Country). Philadelphia Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles H.Smith

(Address) 702 East E.St.Sparrows Pt.

15-

Filed AUG 3 1920, 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 2 1920 (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Burns while playing with matches

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) ..... M. D.

8-2-20, 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Sparrows Pt.Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cmetry	Aug 4 1920
20-UNDERTAKER	ADDRESS
John F Lemmy	715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. All items must be carefully and correctly answered, as they are important. See instructions on back of certificate.

D 45371 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45371

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 718 Light St. St. 27 Ward) Registered No. C 104

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Earnest

(Residence in Baltimore: No. 718 Light St. St.; yrs., 7 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Single.

6-DATE OF BIRTH, December 20th. 1920., 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
------yrs. 7 mos. 13 dys.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, William Earnest

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Helen Burke.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Earnest. (mother)

(Address) 718 Light St.

15- Filed AUG 3 1920 191 G. H. Grese Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 2nd. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto W Bernhardt M. D. (Coroner)

Aug. 2..., 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross Cem. (Harford)	Aug 3..., 1920
20-UNDERTAKER	ADDRESS
F. A. Frame & Son	703 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation important. See instructions on back of certificate.

D45372 HEALTH DEPARTMENT—CITY OF BALTIMORE D45372

CERTIFICATE OF DEATH.

1562

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1603 & Trail ST.: 3 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Jay Pierrepont

(Residence in Baltimore: No. 1603 Pratt St

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Widowed

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 76 yrs. 10 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Chas W Lloyd

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary M Smith

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas W Lloyd

(Address) 3401 Maryland Av

15-

Filed AUG 3 1920 GG

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 1, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock & leg Amputation
Pulmonary Tbc

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Wilbur Lyon M. D.
(Coroner)

July 2, 1920 (Address) 610 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cemetery	Aug 2, 1920
20-UNDERTAKER	ADDRESS
J F Henry & Co	200 Baltimore.

N.B.—Every question must be answered. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

845373 — 91 — 045373

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3161 Schroeder ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fauntain Leroy Jackson

(Residence in Baltimore: No. 3161 Schroeder St.; 0 yrs., 3 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colord

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, March 19, 1920 (Month) (Day) (Year)

7-AGE, ... yrs. 4 mos. 29 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country), Baltimore City and

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ruth Jackson

(Address) 316 W Schroeder St

15-

Filed AUG 3 1920

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 2, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 30 1920, to Aug 2 1920, that I saw h.. alive on Aug 1 1920, and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary) none

(Duration) ... yrs. ... mos. ... ds.

(Signed) R B Kenyon M. D.

Aug 2, 1920 (Address) 609 W Fremont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn cem — DATE OF BURIAL, Aug 4th, 1920

20-UNDERTAKER Daniel Easton — ADDRESS 916 Lemmon av

USE OF DEATH in plain terms. If any important. See instructions on back of certificate.

D.45374 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45374

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1705 Byrd Street. ST. 24 WARD) REGISTERED No. C 150

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME — — - -Fekays.

(Residence in Baltimore: No. 1705 Byrd Street. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White	Single.

6-DATE OF BIRTH, ...August 2nd, 1920...., 1 .....
(Month) (Day) (Year)

7-AGE, ---- yrs. ---- mos. ---- ds. If LESS than 1 day, 1 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None. 8d
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Michael Fekays.

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER Jennie Lehr.

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Lehr. (mother).

(Address) 1705 Byrd St.

15- AUG 3 1920 Robert P. Harrison,
Filed ....., 191....
Burial Permit Clerk, Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...August 2nd, 1920....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Theo. Reinhard M. D.
(Coroner.)
Aug. 3rd, 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Cross Cemetery	Aug. 3rd., 1920
20-UNDERTAKER	**ADDRESS**
E. J. Fanning	1460 Battery Ave.

D.45375 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45375

CERTIFICATE OF DEATH.

REGISTERED No. C. 1047

(PLACE OF DEATH
CITY OF BALTIMORE (No. 1921 Wilhelm St.: 20 WARD)
2-FULL NAME Raymond Hartman
(Residence in Baltimore: No. 1921 Wilhelm St.; yrs., 9 mos. 22 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	Single

6-DATE OF BIRTH, Oct (Month) 11 (Day), 1920 (Year)

7-AGE, ... yrs. 9 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Albert Hartman

11-BIRTHPLACE OF FATHER (State or Country). Balto City

12-MAIDEN NAME OF MOTHER Edna Turner

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Hartman

(Address) 1921 Wilhelm St.

15- Filed AUG 3 1920, 191 Robert F. Hartsock, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 2 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cholera Infantum
(Jaundice 24 hours)
(Duration)..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)
(Duration)..... yrs. ..... mos. ..... ds.

(Signed) James McHenlon M. D.
(Coroner.)
Aug 3, 1920 (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Aug 4, 1920

20-UNDERTAKER Lester Johnson & Bro — ADDRESS 2101 Eutaw Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D.45376 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45376

CERTIFICATE OF DEATH.

64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 Walbrook Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary F. Pinchey

(Residence in Baltimore: No. 2104 Walbrook Ave St.; 70 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, June 10, 1850 (Month) (Day) (Year)

7-AGE, 70 yrs. 1 mos. 22 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Alex. Barnhart

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Catherine Kerns

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar Winterburn

(Address) 2104 Walbrook Ave

15-
Filed AUG 3 1920, 191.....
Robert [illegible]
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 3 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11 1919, to Aug 2 1920, that I saw h[illegible] alive on Aug 2 1920, and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Paralysis (Cerebral Hemorrhage)

(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) O. R. Dwoes M. D.

Aug 3, 1920 (Address) 1817 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Aug 5, 1920

20-UNDERTAKER Harry W. Eden ADDRESS 1944 W. North Ave

CAUSE OF DEATH. See instructions on back of certificate. important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45377 HEALTH DEPARTMENT—CITY OF BALTIMORE D45377

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1707 W. Lombard St ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clayton M. Wright

(a) RESIDENCE. No. 1707 W. Lombard St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Sadie E. Wright

6 DATE OF BIRTH (month, day, and year) March 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of Industry, business, or establishment in which employed (or employer) B & O R.R.

(c) Name of employer B & O R. R.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Sadie E. Wright

(Address) 1707 W. Lombard St.

15 Filed AUG 3 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1920, to Aug. 1, 1920, that I last saw h.. alive on Aug. 1, 1920, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows: Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 3 mos. 7 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) James L Kerbaugh M. D.

8/1. 1920 (Address) 1729 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	8-4-1920.
20 UNDERTAKER Joseph P Cook	ADDRESS 603 W Fayette St

CAUSE OF DEATH in plain terms. Abbreviations not to be used. Indefinite terms, such as "Old Age," "Debility," "Exhaustion," "Heart Failure," "Paralysis," "Convulsions," "Cancer," "Tumor," "Abscess," "Child-bed," "Fever," "Inflammation," "Hemorrhage," "Ulceration," "Consumption," "Dropsy," "Cholera," "Cholera Morbus," "Lung Fever," "Pneumonia," "Bronchitis," "Meningitis," "Blood Poisoning," "Locomotor Ataxia," "Uremia," "Septicemia," "Pyemia," "Gangrene," "Marasmus," "Tuberculosis," "Scrofula," "Jaundice," "Premature Birth," "Stillborn," "Infantile Disease," "Childhood," "Teething," "Whooping Cough," "Measles," "Scarlet Fever," "Diphtheria," "Croup," "Erysipelas," "Smallpox," "Typhoid Fever," "Typhus Fever," "Malarial Fever," "Spinal Disease," "Spinal Irritation," "Spinal Meningitis," "Brain Disease," "Brain Fever," "Kidney Disease," "Bright's Disease," "Liver Complaint," "Stomach Trouble," "Bowel Complaint," "Diarrhoea," "Dysentery," "Colic," "Worms," "Rheumatism," "Neuralgia," "Female Complaint," "Childbirth," "Miscarriage," "Abortion," "Unknown," "Sudden," "Accident," "Fracture," "Injury," "Homicide," "Suicide," "Drowning," "Found Dead," "Burns," "Scalds," "Coroner's Case," "Not Known," "Supposed," "Apparently," "Probably," "Perhaps," "Don't Know," "Don't Remember," "Don't Recollect," "Don't Think," "Don't Believe," "Don't Suppose," "Don't Understand," "Don't Remember Hearing," "Don't Remember Seeing," "Don't Remember Reading," "Don't Remember Writing," "Don't Remember Thinking," "Don't Remember Feeling," "Don't Remember Knowing," "Don't Remember Saying," "Don't Remember Doing," "Don't Remember Anything," "Don't Remember Nothing," "Don't Remember Something," "Don't Remember Anybody," "Don't Remember Anywhere," "Don't Remember Anyhow," "Don't Remember Anyway," "Don't Remember Anyplace," "Don't Remember Anytime," "Don't Remember Anyone

Spec. 6-9-19—H. P. Co.—1000 Bks.

D. 45378 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 45378

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 Cedar Ave Block Park St.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Virginia Bergman

(a) RESIDENCE. No. 208 Cedar Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April 4th 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles A Bergman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden

12 MAIDEN NAME OF MOTHER: Maud Galland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Canada

14 Informant (Address): Chas A Bergman 208 Cedar Ave

15 Filed AUG 3 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug - 2 1920

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1920, to Aug 2, 1920, that I last saw h[illegible] alive on Aug 2, 1920, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows: Gastro enteritis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Vomit. + Stools.

(Signed) R. B. Newell, M. D.

(Address) 3143 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 4 1920
20 UNDERTAKER	ADDRESS
A. J. Mansfield	3538 Gough St

CAUSE OF DEATH must be given. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

No. 45379 HEALTH DEPARTMENT—CITY OF BALTIMORE No. 45379

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 W. 25th St. ST.: 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Almeda Fitz Gerald Everhart

(a) RESIDENCE. No. 100 W. 25th ST., 12 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Xavier Everhart

6 DATE OF BIRTH (month, day, and year) July 27 1875

7 AGE: Years 45 | Months | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fulton Chester Co Pa.

PARENTS

10 NAME OF FATHER Edmond Fitz Gerald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila. Penn

12 MAIDEN NAME OF MOTHER Phoebe A. Keen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chester Co. Pa.

14 Informant Dr. Geo. E. Cooper

(Address) 100 W. 25th St.

Filed AUG 5 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3rd 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 16th, 1920, to Aug. 3rd, 1920, that I last saw her alive on Aug. 3rd, 1920, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo E Cooper, M. D.

, 19 (Address) 100 W. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Shrewsbury Pa

DATE OF BURIAL: Aug 5 19 20

20 UNDERTAKER: A S Marshall

ADDRESS: 3139 Fall Rd

CAUSE OF DEATH in plain terms, so that any physician can understand it. Do not use abbreviations or technical terms. Name contributory (secondary) causes if any. See instructions on back of certificates. ATTENTION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D45380

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45380

CERTIFICATE OF DEATH.

151

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin & Schroeder ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Shroff

(Residence in Baltimore: No. Nursery & Childs Hospital: — yrs., 6 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) —

6-DATE OF BIRTH, Jan. 27, 1920 (Month) (Day) (Year)

7-AGE, — yrs. 6 mos. 7 da.

If LESS than 1 day, ...hrs. or....mtn.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Douglas Williams

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Shroff

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred C. Sohn

(Address) Nurses Childs Hospital

15-

Filed AUG 4 1920, 191.... G. H. Grese Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 3 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15 1920, to Aug 3 1920, that I saw h[illegible] alive on Aug 3 1920, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Acute Intermussein

(Duration) — yrs. — mos. 22 ds.

CONTRIBUTORY (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) I. J. Feinglass M. D.

Aug 3..., 1920 (Address) 2002 E. Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 22 ds. In the State ....yrs. 6 mos. 7 ds.

Where was disease contracted, if not at place of death? —

Former or usual residence St. Vincents Orphanage

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Aug. 4., 1920

20-UNDERTAKER George J Smith

ADDRESS 1000 Fayette St

IMPORTANT. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D45381

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45381

CERTIFICATE OF DEATH.

1-PLACE OF DEATH. (Usual residence.) CITY OF BALTIMORE: (NO.) Howard Alley bet. 5th & 6th Sts. near 2nd Ave. (ST.;) Fairfield (WARD) 25

REGISTERED NO. C 1192

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hazel Carter

(Residence in Baltimore: No. Above address St.; 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Month & day not known (Month) (Day) 1886 (Year)

7-AGE, 34 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Fertilizer factory

9-BIRTHPLACE, (State or Country), South Carolina

PARENTS.

10-NAME OF FATHER, Hazel Gore

11-BIRTHPLACE OF FATHER (State or Country), S. C.

12-MAIDEN NAME OF MOTHER Annie Carter

13-BIRTHPLACE OF MOTHER (State or Country), S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Carter

(Address) Fearfield Md. Ave.

15- AUG 4 1920, 191... G. H. Grese Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 2nd, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 26 1920, to Aug 2 1920, that I saw him alive on Aug 2 1920, and that death occurred, on the date stated above, at 6:30 p m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

Coma

(Duration) yrs. mos. 1 d. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Leo Evans M. D.

Aug 3, 1920 (Address) 211 Church St. Centre Bldg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Furnes Branch

DATE OF BURIAL, Aug 5, 1920

20-UNDERTAKER R. B. Frost

ADDRESS 1405 McElderry St

important. See instructions on back of certificate.

Patient went by name of step father

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45382 HEALTH DEPARTMENT—CITY OF BALTIMORE D45382.

154

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Sheer

(a) RESIDENCE. No. 1233 E. Monument ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Sheer

6 DATE OF BIRTH (month, day, and year) Unknown 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
58		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cap-maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records

15 Filed AUG 4 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

t6 DATE OF DEATH (month, day, and year) Aug. 3 1920

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1920, to Aug 3, 1920.

that I last saw him alive on Aug 3, 1920.

and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Senility

(duration) yrs. mos. ds.

t8 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) N. Friedrich, M. D.

8-3-20, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Henning Run	8/4 1920
20 UNDERTAKER Jack Levis	ADDRESS 1411 E Balto

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

845383

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 845383

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital 4 St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Lee

(a) RESIDENCE. No. 231 Harrison St. St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? 51 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. McCann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed AUG 4 19 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1920, to Aug. 3 1920, that I last saw her alive on Aug. 2 1920, and that death occurred, on the date stated above, at 12.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? T. B. in sputum

(Signed) L. S. Fahndrich, M. D.

8-3-20, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Aug 4 1920
20 UNDERTAKER Samuel Hemsley	ADDRESS 578 N Bond

CAUSE OF DEATH on plain surface above. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45384

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45384

CERTIFICATE OF DEATH.

176

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1005 Watson ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Sody

(a) RESIDENCE. NO. 1005 Watson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jacob Sody

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Sody
(Address) 1634 Ellison st

15 Filed AUG 4 1920 G. H. Grese Registrar

CAUSE OF DEATH to be written in plain terms. Abbreviations on back of certificates. TION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/3. 1920

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1920, to August 1, 1920, that I last saw h.m alive on August 2, 1920, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis

(Signed) Charles L. Levy, M. D.

8-3. 1920 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL Aug 1920

20 UNDERTAKER Maf Linton

ADDRESS 1127 E Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45385 D45385

CERTIFICATE OF DEATH.

151

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2018 McCulloh St., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Arthur & Edith Johnson

(Residence in Baltimore: No. 2018 McCulloh St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	C	Single

6-DATE OF BIRTH, August 2, 1920 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs....mos....ds.	11 hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Arthur Johnson

11-BIRTHPLACE OF FATHER (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER Edith Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Edith Johnson

(Address) 2018 Mc Culloh

15-

Filed....., 191.....

AUG 4 1920 G. H. Grese Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 3, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 2 1920, to Aug 3 1920, that I saw him alive on Aug 2 1920, and that death occurred, on the date stated above, at 24 m.

The CAUSE OF DEATH* was as follows:

Immature Birth

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration)...yrs...mos...ds.

(Signed) H. & M. Earp M. D.

8/3, 1920 (Address) 2005 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Lamar Cem. DATE OF BURIAL, Aug 4 1920

20-UNDERTAKER Geo. W. Holland ADDRESS 1631 Druid Hill Ave

Spec.—8-24-14—M. & T.—2000 Bks.

245386 HEALTH DEPARTMENT—CITY OF BALTIMORE 245386

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1120 Pennington Ave St.; (WARD) 12th

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Lutka

(Residence in Baltimore: No. 1120 Pennington Ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Infant

6-DATE OF BIRTH, May (Month) 18 (Day), 1920 (Year)

7-AGE, ...yrs. 2 mos. 14 ds.

If less than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country) Curtis Bay

PARENTS.

10-NAME OF FATHER, Wojciech Lutka

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER, Josefa Kopacek

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josefa Lutka

(Address) 1120 Pennsylvania Ave

15- AUG 4 1920 G. H. Grace

Filed ...., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 3 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 2 1920, to Aug. 3 1920, that I saw her alive on Aug 2 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

.... (Duration) ....

CONTRIBUTORY (Secondary) ....

.... (Duration) ....yrs. ....mos. ....ds.

(Signed) Hugo B. Hanau M. D.

Aug 3, 1920 (Address) 1 Cedar St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill — DATE OF BURIAL, Aug 4, 1920

20-UNDERTAKER Frank Cvach & Sons — ADDRESS Ashland

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

845387

HEALTH DEPARTMENT—CITY OF BALTIMORE

2845387

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 Prospect Ave ST.; 13 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William L. Love

(Residence in Baltimore: No. 127 Prospect Ave St.; 42 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, April 7, 1878. (Month) (Day) (Year)

7-AGE, 42 yrs. 3 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): 031

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, George Love

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Sarah Spencer

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Della B. Love

(Address) 127 Prospect Ave

15-

Filed ....., 191.....

AUG 4 1920

G. H. Gross
Registrar.

Cross out words not important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 3, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 1918, to Aug 3 1920, that I saw h[illegible] alive on Aug 3 1920, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema,
Exhaustion — Phalmelution

(Duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(Duration) 2 yrs. mos. ds.

(Signed) Vernon F. Kelly M. D.

Aug 3., 1920 (Address) 5705 Falkirk

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL, Aug 4, 1920

20-UNDERTAKER Jas. Sykes Hooper — ADDRESS 1600 W North ave

D45388 HEALTH DEPARTMENT—CITY OF BALTIMORE 104 D45388

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 933 E. Madison St. 10 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elenora Booker

(Residence in Baltimore: No. 933 E. Madison St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	Col.	Mar

6-DATE OF BIRTH, May 3, 1920
(Month) (Day) (Year)

7-AGE, yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER Sam. Booker

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Musa Payne

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Musa Booker

(Address) 933 E Madison St

15- AUG 4 1920 G. F. Gross

....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 3, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(Duration) yrs. mos. ds.

(Signed) J. Wirt Insley M. D.
(Coroner.)

8-3 1920 (Address) 4 E. Oliver

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Asbury Cemetery	Aug 4 1920
20-UNDERTAKER	ADDRESS
Milton Davis	1112 N Eden St

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

D45389 HEALTH DEPARTMENT--CITY OF BALTIMORE D45389

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C 28

CITY OF BALTIMORE (No. 1507. W. Pratt. ST: 8 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Loretta M. Huston.

(Residence in Baltimore: No. 1507. W. Pratt St. St.: 35 yrs. 2 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	married

6-DATE OF BIRTH May (Month) 29 (Day), 1885 (Year)

7-AGE 35 yrs. 2 mos. 4 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Baltimore. Md.

PARENTS

10-NAME OF FATHER Jos. E. Bushbaum.

11-BIRTHPLACE OF FATHER (State or country) Baltimore. Md.

12-MAIDEN NAME OF MOTHER Mary C. Smith.

13-BIRTHPLACE OF MOTHER (State or country) Baltimore. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry E. Huston

(Address) 1507 W Pratt St

15- Filed AUG 4 1920 G. H. Grese. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH August (Month) 2 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 27, 1920, to. August 2 1920, that I saw her alive on August 2, 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration) — yrs. 2 mos. 6 ds

Contributory (SECONDARY) Exhaustion

(Duration) ? yrs. 2 mos. 6 ds.

(Signed) Frederick. C. Hoenes. M. D.

August 2, 1920. (Address) 112. Broadway.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL St Peters Cem | DATE OF BURIAL Aug 5 1920

20-UNDERTAKER Harry Abrahamson | ADDRESS 4204 Edgewood Ave

N. B.-Every item of information should be carefully supplied. Avoid using ditto marks. Write plainly in ink. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45390 HEALTH DEPARTMENT—CITY OF BALTIMORE D45390

CERTIFICATE OF DEATH. 50

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3131 Guilford ave (St.) W (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Charles Keene

(a) RESIDENCE. No. 3131 Guilford ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. — mos. — ds. How long in U. S., if of foreign birth? 26 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosina M. Keene

6 DATE OF BIRTH (month, day, and year) Apr 22-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 076

(b) General nature of industry, business, or establishment in which employed (or employer) Chemist

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Isaac Keene

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Henrietta —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Rosina M. Keene
(Address) 3131 Guilford Ave

15 Filed AUG 4 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1920

17 I HEREBY CERTIFY, That I attended deceased from July 31 1920 to Aug 3 1920, that I last saw h.[illegible] alive on Aug 3 1920, and that death occurred, on the date stated above, at 6 to 9 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Melvin L. Kreuthal, M. D.

7/3. 1920 (Address) 1222 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chev Sholam Cem	7/4 1920

20 UNDERTAKER David Sondheim ADDRESS 1189 W. Mt Royal ave

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

D45391 HEALTH DEPARTMENT—CITY OF BALTIMORE D45391

CERTIFICATE OF DEATH.

172

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Square Hospital St.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oliver T Rothaggr

(Residence in Baltimore: No. 1204 Glyndon ave St.: yrs. 8 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Mal	white	Sing'l

6-DATE OF BIRTH, ... March (Month) 15 (Day), 1912 (Year)

7-AGE, ... 8 yrs. 3 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School no
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, Thomas Rothagg

11-BIRTHPLACE OF FATHER (State or Country), Balto ct

12-MAIDEN NAME OF MOTHER Anita Slater

13-BIRTHPLACE OF MOTHER (State or Country), maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anita E Rothagg

(Address) 1204 Glyndon ave

15- AUG 4 1920

Filed....., 191... G. H. Gress. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug (Month) 3 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) and that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull, by fall from a ladder while at play (Duration) ..... yrs. ..... mos. 1/2 da.

CONTRIBUTORY (Secondary) Hemorrhage & Brain

(Duration) ..... yrs. ..... mos. 1/2 da.

(Signed) James M Kemp M. D. (Coroner)

Aug 4. 1920 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Franklin Sq Hos In the state ..... yrs. ..... mos. ..... da.
of death ..... yrs. ..... mos. 2 da.

Where was disease contracted, if not at place of death? .....

Osland & Jones St

Former or usual residence 1204 Glyndon ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cem	Aug 6..., 1920
20-UNDERTAKER Robert Brookes	ADDRESS Gathers burg

CAUSE OF DEATH to plain terms, so that it may be properly important. See instructions on back of certificate.

D45392 HEALTH DEPARTMENT--CITY OF BALTIMORE D45392

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1457 Parrish ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachel Johnson

(Residence in Baltimore: No. 1457 Parrish St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F.	C	Widowed

6-DATE OF BIRTH, Not known. (Month) (Day), 1861 (Year)

7-AGE, 59 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook.
(b) General nature of industry, business, or establishment in which employed (or employer): 21

9-BIRTHPLACE, (State or Country) Carroll Co. Md.

PARENTS.

10-NAME OF FATHER, — — Johnson

11-BIRTHPLACE OF FATHER (State or Country) Carroll Co. Md

12-MAIDEN NAME OF MOTHER Harriet Butler

13-BIRTHPLACE OF MOTHER (State or Country) Carroll Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H. Dennis

(Address) 1303 Prestmanst

15- AUG 4 1920., 191..... G. H. Grese Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 / 2 / 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion (Duration) ....yrs. ....mos. 1 hr. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficency (Duration) ....yrs. ....mos. 1 hr. ds.

(Signed) F. C. Blades M. D. (Coroner.)

8/2/20. 191... (Address) 1436 N. Bway

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn — DATE OF BURIAL, Aug 5 1920

20-UNDERTAKER JAMES H. DENNIS — ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of cause important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45393 HEALTH DEPARTMENT—CITY OF BALTIMORE D45393

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1442 Brunt ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie Hudnall

(a) RESIDENCE. No. 1442 Brunt ST., WARD. 13.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Light Housework

(c) Name of employer None.

9 BIRTHPLACE (city or town) (State or country) Northumberland Co. Va.

PARENTS

10 NAME OF FATHER John Hudnall

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Maria Penn

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Wm. C. Hudnall

(Address) 1442 Brunt

15 Filed Aug 4 1920, 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1920

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1920, to Aug 4, 1920, that I last saw h alive on Aug 4, 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronic

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Va.

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical symptoms

(Signed) Jno H Wright M. D.

Aug 4. 1920 (Address) 1204 Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Blackwell Va	Aug. 14 1920
20 UNDERTAKER Blackwell Undg Co	ADDRESS
Edw. Ruggold	1463 Arey St

CAUSE OF DEATH in plain terms, so that it may be a guide in the preparation of certificates. TION is very important. See instructions on back of certificates.

D. 45394

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45394 HEALTH DEPARTMENT—CITY OF BALTIMORE 1920

Giles A. Puett

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hospital ST.. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Giles Puett

(a) RESIDENCE. NO. 1201 N Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Ella S. Puett

6 DATE OF BIRTH (month, day, and year) June 20 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dairyman 45

(b) General nature of industry, business, or establishment in which employed (or employer) Dairy Industry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Puett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Ella S. Puett

(Address) 1201 N. Bond St

15 Filed AUG 4 1920 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1920, to Aug 3rd 1920, that I last saw him alive on Aug. 3 1920, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J. C. Mason, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery Co.	Aug 6 1920
20 UNDERTAKER Henry Hauck Son	ADDRESS 130 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TIONS very important. See instructions on back of certificates.

Spec.—6-8-19—H. P. Co.—1000 Blks.

D45395 HEALTH DEPARTMENT—CITY OF BALTIMORE D45395

CERTIFICATE OF DEATH. 119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Bolton St.; 8 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina M. Knoedler

(a) RESIDENCE. NO. 12 Bolton Lane ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 8 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Wht.	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Geo B. Knoedler

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frank Kaner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Eckell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Geo B. Knoedler (Address) 12 Bolton Lane

15 Filed AUG 4 1920 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1920

17 I HEREBY CERTIFY, That I attended deceased from July 31 1920, to Aug 3 1920, that I last saw h[illegible] alive on Aug 2 1920, and that death occurred, on the date stated above, at 4.50 a. m.

The CAUSE OF DEATH* was as follows:

DPW

Acute Nephritis

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. L. Hooper, M. D.

21. 19[illegible] (Address) 3402 E. 28th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug 5 1920
20 UNDERTAKER	ADDRESS
Henry Koeck & Son	1301 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45396 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45396

CERTIFICATE OF DEATH. 18

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Dorchester Eight 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gloriso

(a) RESIDENCE. No. Dorchester Eight 25 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Feb 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joe Glorioso

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Dinci

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Joe Glorioso (Address) Dorchester Eight 25

15 Filed AUG 4 1920 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1920

17 I HEREBY CERTIFY, That I attended deceased from 7-19-, 1920, to 8-4-, 1920, that I last saw h[illegible] alive on 8-3-, 1920, and that death occurred, on the date stated above, at 12.30 A. m.

The CAUSE OF DEATH* was as follows:

Erysipelas migrans vulva & extremities (lower) & back -

(duration) yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) Erysipelas migrans

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) S. Tomarchio M. D.

, 19 (Address) 1604 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 8-4 1920

20 UNDERTAKER Joe D'Aloia Store

ADDRESS 1318 Eager

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.45397

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45397

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 William ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Gaither

(a) RESIDENCE. No. 918 William ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of XXXXXXXXXXXXXXXXXXXXXX

6 DATE OF BIRTH (month, day, and year) Jan.28 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Wharf

(c) Name of employer Incapacitated

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John W.Gaither

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Marie D.Horner

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant Marie D.Gaither
(Address) 918 William St.

15 Filed AUG 4 1920 19 Robert J. ... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug.2 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1920 to Aug 2, 1920 that I last saw him alive on Aug 2, 1920, and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows: Cerebral Paralysis DTW

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Mamie Coma

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) W. Hammer Linder, M. D.

Aug 3 1920 Address) 830 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MOUNT OLIVET.	AUG 5 - 1920

20 UNDERTAKER JOHN F. DENNY ADDRESS 715 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

20.45398 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.45398

CERTIFICATE OF DEATH.

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 Frederick St, Brooklyn St.; 25 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Henry Hardy

(Residence in Baltimore: No. 407 Frederick St. St.; ..... yrs., ... mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M.	C.	Single

6-DATE OF BIRTH, July 17, 1920
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 18 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, George Edward Hardy Jr.

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Maggie Mary Green

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. E. Hardy Jr.

(Address) 407 Frederick St Brooklyn

15- AUG 4 1920, 191.....
Robert P. Harrison,
Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 4th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 17 1920, to Aug 4th 1920, that I saw him alive on Aug 3 1920, and that death occurred, on the date stated above, at 3:15 a.m.

The CAUSE OF DEATH* was as follows:

Congenital debility

(Duration) ..... yrs. ..... mos. 18 ds.

CONTRIBUTORY (Secondary) Acute gastro-enteritis

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Geo. E. Davis M. D.

Aug 4th, 1920 (Address) 211 Church St. Locust Pt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Furnace Branch	AUG 6 1920 191...
20-UNDERTAKER JOHN F. DENNY	ADDRESS 716 LIGHT ST.

CAUSE OF DEATH must be stated in plain English. See instructions on back of certificate.

D.45399 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45399

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — CITY OF BALTIMORE (No. Off Globe Shipbuilding Plant. ST.: Brooklyn. WARD) 25 + 169

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert L.Sanford.

(Residence in Baltimore: No. Brooklyn. St.; yrs., 2 mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, September 20th. 1903., 1 (Month) (Day) (Year)

7-AGE, 16 yrs. 10 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Deck hand.
(b) General nature of industry, business, or establishment in which employed (or employer): 074

9-BIRTHPLACE, (State or Country), Westmoreland Co Va

PARENTS.

10-NAME OF FATHER, M. Filmore Sanford.

11-BIRTHPLACE OF FATHER (State or Country), Westmoreland Co Va

12-MAIDEN NAME OF MOTHER Edna Rowe.

13-BIRTHPLACE OF MOTHER (State or Country), Westmoreland Co. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lynwood L.Sanford.(brother)

(Address) Westmoreland Co.Va.

15-

Filed AUG 4 1920, 191.

Robert P. Harrison, Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 3rd. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.
Accidental fall from a scow.
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)
(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

Aug 4, 1920 (Address) 1910 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Chulton Westmoreland Co. Va.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Chulton Va	Aug. 4, 1920

20-UNDERTAKER John F Denny ADDRESS 73 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Omit abbreviations. Be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-2419
D.45400

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45400

CERTIFICATE OF DEATH.

74

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: [illegible] WARD)

2-FULL NAME. Sarah Elizabeth Whitely.

(a) RESIDENCE. No. 507 Beaumont Av. Govans Md WARD. H.L.H. ??
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2yr mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 5 - 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm E. Whitely

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Louisa Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J. H. Bennett
(Address)

15 Aug 4 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1920, to Aug 3 -, 1920, that I last saw h Er alive on Aug 3 -, 1920, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Epilepsy, Jacksonian.
Hem Sp Cyst

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation - Surgical Shock - (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 3, 1920

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Mont R. Reed, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 5 1920

20 UNDERTAKER William Cook ADDRESS 1028 E Fayette

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.45401 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.45401

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1437 E. Fort Ave (St.) 24 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. L. Rankin

(a) RESIDENCE. No. 1437 E. Fort Ave. St.. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie A. Rankin.

6 DATE OF BIRTH (month, day, and year) March 28 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer) 857

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boston Mass

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant (Address) Minnie A. Rankin 1437 E. Fort Ave

15 Rec'd AUG 4 1920 Robert L. ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1920.

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1920, to Aug 2, 1920, that I last saw him alive on July 31, 1920, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Urinary Bladder

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of May 1920

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hubert T. Knapp, M. D.

Aug 3 1920 (Address) 1216 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park.	Aug 6 1920.
20 UNDERTAKER	**ADDRESS**
William Cook	520 E North.

CAUSE OF DEATH to be filled in plainly with ink or indelible pencil. Read carefully the Rules and Regulations for the Registration of Births and Deaths and the Duties of Undertakers and Physicians. Every question must be answered. Omission to answer any question will cause delay in issuing burial permit. Read carefully the Rules and Regulations for the Registration of Births and Deaths and the Duties of Undertakers and Physicians. Every question must be answered. Omission to answer any question will cause delay in issuing burial permit. See instructions on back of certificates. CAUSE OF DEATH to be filled in plainly with ink or indelible pencil. Read carefully the Rules and Regulations for the Registration of Births and Deaths and the Duties of Undertakers and Physicians. Every question must be answered. Omission to answer any question will cause delay in issuing burial permit. See instructions on back of certificates. TION is very important.

Spcc.—6-9-19—H. P. Co.—1000 Bks.

D.45402 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45402

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1737 Mulliken ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Stanley

(a) RESIDENCE. No. 1737 Mulliken ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of — Stanley

6 DATE OF BIRTH (month, day, and year): 1852

7 AGE: Years 69 Months Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Minnie Smith, daughter
(Address): 1737 Mulliken

15 Filed AUG 4 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1920, to Aug 2, 1920, that I last saw h alive on Aug 2, 1920, and that death occurred, on the date stated above, at 8.30 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Cerebral Apoplexy

Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an antopsy?

What test confirmed diagnosis?

(Signed) W. F. Burns, M. D.

Aug 3, 1920 (Address) 2215 Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Aug 3 1920

20 UNDERTAKER: Thos S Bailey

ADDRESS: 421 Jefferson st

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 75403

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 75403

CERTIFICATE OF DEATH.

104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 S. Linwood Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helena Waslewska

(Residence in Baltimore: No. 722 S. Linwood Ave St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec (Month) 15 (Day), 1919 (Year).

7-AGE, ...yrs. 7 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Waslewski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Mary Kramer

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Wasilewski

(Address) 722 S Linwood Ave

15-

Filed AUG 4 1920, 191... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 3rd (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1920, to Aug 3 - 1920, that I saw h[illegible]alive on Aug 3 1920, and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows: T P

Gastro Enteritis

5

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas L. Iser M. D.

8/4/20, 191... (Address) 404 E Bat[illegible] Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus Cem

DATE OF BURIAL, Aug 5, 1920

20-UNDERTAKER Stephen J Trzaskowski

ADDRESS 1005 S Kenwood Ave

CAUSE OF DEATH must be stated plainly and accurately. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 45404

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45404

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1925 E Eager ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Skarda

(a) RESIDENCE. No. 1925 E. Eager ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Skarda

6 DATE OF BIRTH (month, day, and year) Nov. 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER [illegible] Skarda

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant James Skarda (Address) 1925 E Eager St.

15 Filed AUG 5 1920 G. H. Grese, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3, 20 to Aug 3, 20, that I last saw him alive on Aug 3, 20, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Trouble (duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William J. Krause M. D.

Aug 3, 1920 (Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 5 1920
20 UNDERTAKER Frank Grach Sr	ADDRESS 1766 Bank Street

CAUSE OF DEATH in plain terms, so that it may be properly classified. Any delay in filing certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 45405

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 45405

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital ST.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Constantini

(a) RESIDENCE. NO. 637 W. Lexington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Herman Constantini

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER V. Falcone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Herman Constantissi

(Address) 637 W Lexington St

15 Filed AUG 5 1920 Registrar C. H. Grix

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4 1920.

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1920, to August 4, 1920, that I last saw him alive on August 3, 1920, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis.

(duration) yrs. mos. 14. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) C. Gilbert Stewart. M. D.

8/4. 1920 (Address) Maryland General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Aug 5 1920
20 UNDERTAKER	ADDRESS
H M Routson	2038 Greene

NOTE—Information should be carefully supplied. AGE should be given in every case. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45406

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D45406

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 S Bose ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine Luckhardt.

(a) RESIDENCE. NO. 817 S Bose ST., 1 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 19 1849

7 AGE 70 Years [redacted] Months 15 Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Brickart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Henry J. Luckhardt (Address) 817 S Bose St

15 Filed AUG 5 1920 Registrar C. H. Grese.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1920

17 I HEREBY CERTIFY, That I attended deceased from July 26 1920, to Aug 2 1920, that I last saw h alive on Aug 2 1920, and that death occurred, on the date stated above, at 1 15 AM m.

The CAUSE OF DEATH* was as follows:

acute Dysentery

Ileo-Colitis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Hr arthritis Chronic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological Examination

(Signed) C. L. Long M. D.

8-3, 1920 (Address) 2701 Eastern Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwarz Cemetery	May 6 19 20
20 UNDERTAKER	ADDRESS
Louis Heumann	32 S Broadway

CAUSE OF DEATH must be filled in. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45407 V

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D45407

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 W Fayette ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leroy F. Henkle

(a) RESIDENCE. NO. 825 W. Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Leroy C. Henkle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Helen G. Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Leroy C. Henkle

(Address) 825 W. Fayette St.

15 Filed AUG 5 1920 19 C. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1920

17

I HEREBY CERTIFY, That I attended deceased from July 28 1920 to Aug 4 1920.

that I last saw him alive on Aug 4 1920.

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Colitis (duration) yrs. mos. 7 ds.

CONTRIBUTORY - Exposure and improper diet (duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. F. Hanna M. D.

(Address) 1311 Fremont St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 5 1920
20 UNDERTAKER	ADDRESS
Mr & Mrs John W Zepf	804 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Information required in every case. Do not use abbreviations or symptoms. If unknown, state the fact. Do not return this certificate to the undertaker. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

845408 845408

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1712 McCulloh St.; 14 WARD) REGISTERED NO. C 51

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Maria Wood & Edgar Braxton

(Residence in Baltimore: No. 1712 McCulloh St.; ..... yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	C	Single

6-DATE OF BIRTH, Aug (Month) 3 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
.....yrs.....mos.....da.	4 hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... 0
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Edgar Braxton

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Maria Wood

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Smith

(Address) 1712 McCulloh

15-

Filed....., 191.... C. H. Grose Registrar.

AUG 5 1920

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 4 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 3 1920, to Aug 4 1920, that I saw her alive on Aug 4 1920, and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration).....yrs.....mos.....da.

CONTRIBUTORY (Secondary)

..... (Duration).....yrs.....mos.....da.

(Signed) H. J. McCauley M. D.

8/5/, 1920 (Address) 2008 Hillsdale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	Aug 5, 1920

20-UNDERTAKER George H. Holland ADDRESS 1834 Hillsdale

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45409 D.C.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D45409

REGISTERED NO. 666

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 So. Clinton St ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Henson

(a) RESIDENCE. NO. 1611 So Clinton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male.	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Husband

6 DATE OF BIRTH (month, day, and year) 1 April 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
50	Years	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work labor.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer J. S. Young

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Nathan Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Georgia Sims

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Harriet Henson.
(Address) 611 Clinton

15 Filed AUG 5. 1920 H. Grove Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1920, to Aug. 2, 1920, that I last saw him alive on Aug 2, 1920, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Blood Poisions & Cancer of Face & Throat

CONTRIBUTORY (Secondary) Cancer of face Throat (duration) 11 yrs. 6 mos. 9 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leigh Kennard, M. D.

8-5. 1920 (Address) 708 Union St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	aug 5 1920

20 UNDERTAKER ADDRESS

Milton Davis 413 N Eden St

CAUSE OF DEATH in plain terms, so that it may be classified. Do not use abbreviations or ditto marks. Any cause of death which is not a disease should be reported in this space. Any cause of death which is not a disease should be reported in this space. Any cause of death which is not a disease should be reported in this space

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45410

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D 45410

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2610 Bruce Terrace ST.: 13 WARD)

2-FULL NAME William H Sheppard

(a) RESIDENCE. No. 2610 Bruce Terrace ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Deceased Mary R Sheppard

6 DATE OF BIRTH (month, day, and year) June 31-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stair Builder

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Maggie M Sheppard (Address) 2610 Bruce Terrace

15 Filed AUG 5 1920 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1920

17 I HEREBY CERTIFY, That I attended deceased from June, 1919, to Aug 3, 1920

that I last saw him alive on Aug 3, 1920

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Home

(Signed) Fred B Jewett M. D.

Aug 4. 1920 (Address) 2516 Penn. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 7 1920
20 UNDERTAKER	ADDRESS
J W Cook & Son	E North Ave

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45411 D45411

CERTIFICATE OF DEATH

1-PLACE OF DEATH John Hopkins Hospital 37 REGISTERED NO.

CITY OF BALTIMORE: (No. 233 N Montford Av ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arnetta Jordon

(a) RESIDENCE. No. 233 N. Montford Av ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 7, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Douglas Jordan

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER Maude

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant J. H. H. Dispensary Records
(Address)

15 Filed . 19 . C. H. Grose Registrar

AUG 5 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1920

17 I HEREBY CERTIFY, That I attended deceased from July 20 1920 to Aug 4 1920
that I last saw her alive on Aug 3 1920
and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Early hereditary Syphilis

(duration) yrs. 7 mos. 28 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? hereditary

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) Harold L. Higgins M. D.

8/4. 1920 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Aug 5 1920
20 UNDERTAKER Daniel Easton	ADDRESS 916 Pa Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D45412 — 104 D45412

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2818 O'Donnell ST. 1st WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Oszakiewski

(a) RESIDENCE. NO. 2818 O'Donnell ST., 1st WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 3 '20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) infant

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Stephen Oszakiewski

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Lucy Frankowich

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Stephen Oszakiewski
(Address) 2818 O. Donnell St.

15 Filed AUG 5 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1920

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1920, to August 4, 1920, that I last saw him alive on August 3, 1920, and that death occurred, on the date stated above, at 9 :20 A m.

The CAUSE OF DEATH* was as follows:

gastro enteritis — (Toxemia + (exhaustion)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) (Colitis [illegible] + malnutrition)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

(Address) 3048 O'Donnell St. Aug 4. 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Aug. 5 1920

20 UNDERTAKER William Fialkowski ADDRESS 1618 Eastern Ave

mation should be carefully supplied. Answers must be so that it may be properly classified. Exact statement of occupation
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Not a coroners Case

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45413

D two numbers. D 45413

CERTIFICATE OF DEATH.

+ 104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Halcomb

(a) RESIDENCE. NO. 613 Eye St Barrens. Pt. ST. Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 4 - 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER James Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Viola K Halcomb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hosp Records

15 Filed AUG 5 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1920, to Aug 3, 1920, that I last saw him alive on Aug 3 -, 1920, and that death occurred, on the date stated above, at 2 1/2 P m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Patient Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Centrapp M. D.

8-3. 1920 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Home	Aug 5 1920
20 UNDERTAKER	ADDRESS
Sam'l H. Cake Wm	14 Monroe

CAUSE OF DEATH in plain terms, so that it may be understood by the people. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45414 HEALTH DEPARTMENT—CITY OF BALTIMORE D45414

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 Millsman ST.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Robinson

(a) RESIDENCE. NO. 1623 Millsman ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. 1 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A. Robinson

6 DATE OF BIRTH (month, day, and year) June 30-85

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	0		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER George E. Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Hannah A. Ayers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Hannah A. Anderson 1623 Millsman

15 Filed AUG 5. 1920 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3 1920

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1920, to Aug. 3, 1920, that I last saw her alive on Aug. 3, 1920, and that death occurred, on the date stated above, at 1:30 P.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of lungs

Tuberculosis of lungs

(duration) yrs. 4 mos. 1 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. 5 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jos. Maynard M. D.

(Address) 208 Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. DATE OF BURIAL: Aug 6 1920

20 UNDERTAKER: Sam'l W. Cruse Son ADDRESS: 1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations must not be used. Fill in all blanks. Read carefully instructions on back of certificates. TION is very important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45415 V 104 D45415

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 McPhail ST.; 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Lewis Jacobs.

(Residence in Baltimore: No. 116 McPhail St.; yrs., mos., ds.) 6 8

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Infant

6-DATE OF BIRTH, Jan (Month) 27 (Day), 1920 (Year)

7-AGE, no yrs. 6 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Frank Jacobs.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Helen Jennings.

13-BIRTHPLACE OF MOTHER (State or Country), Iowa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Jacobs

(Address) 116 McPhail St

15- Filed AUG 5 1920 191 G. H. Gresse. Registrar.

CAUSE OF DEATH must be plainly filled in. Every item important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 5 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 4 1920, to Aug 5 1920, that I saw him alive on Aug 4 1920, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Obstruction Umbilical cord

(Duration) no yrs. no mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Raymond S Iglauer M. D.

Aug 5, 1920 (Address) Scotland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery

DATE OF BURIAL, Aug 7, 1920

20-UNDERTAKER F. B. Kilpatrick

ADDRESS 2336 Fred'k Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45416 Marie

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 92 D45416

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Renaud Jeu Marie —

(a) RESIDENCE. NO. France — ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. 1 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman (French)

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France —

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Hospital Record
(Address)

15 Filed AUG 5 1920 G. H. Cross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2nd 1920

17 I HEREBY CERTIFY, That I attended deceased from 7/27, 1920, to 8/2, 1920, that I last saw him alive on 8/2/, 1920 and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Right Hypos Middle & Lower Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. R. Goldsborough Jr. M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug 6 1920
20 UNDERTAKER	ADDRESS
Robt J Turner Son	1442 N. Broadway

CAUSE OF DEATH in plain terms, so that a Physician can understand it. Do not use abbreviations or symbols. Read carefully the instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45417

HEALTH DEPARTMENT--CITY OF BALTIMORE

D45417

CERTIFICATE OF DEATH.

130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 444 E. 20th St. ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Everett Harper

(a) RESIDENCE. No. 444 E. 20th St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Everett F. Harper

6 DATE OF BIRTH (month, day, and year) March 12 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tobacconist

(b) General nature of industry, business, or establishment in which employed (or employer) Tobacco Manufacturing

(c) Name of employer B & O. R.R.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm E Harper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Hilen Aug 4 20

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Everett F Harper (Address) 444 E 20th St

15 Filed AUG 5 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1920

17 I HEREBY CERTIFY, That I attended deceased from July 4 1920, to Aug 4 1920, that I last saw h— alive on Aug 4 1920, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Home

(Signed) Geo Musgrave M. D.

(Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Aug 7 1920

20 UNDERTAKER: Wm Corbin — ADDRESS: N. Gay

CAUSE OF DEATH in plain terms, so that it may be understood by the laity. See instructions on back of certificates. TION is very important.

B45418 HEALTH DEPARTMENT—CITY OF BALTIMORE B45418

CERTIFICATE OF DEATH.

104

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 536 n. Eden St. 5. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret D Williams

(Residence in Baltimore: No. 536 n. Eden St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fmale.

4-COLOR OR RACE, col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Mar

6-DATE OF BIRTH, (Month) August (Day) 11 (Year) 1913

7-AGE, yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE (State or Country): born in Baltimore md.

PARENTS.

10-NAME OF FATHER, George Williams

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Annie Baker

13-BIRTHPLACE OF MOTHER (State or Country), in Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Williams

(Address) 536 N Eden St

15- AUG 5 1920 G. H. Grese.

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Aug (Day) 4 (Year) 1920

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Wm. Ingram (Coroner)

191... (Address) 7 E Day

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Ashury Cem — DATE OF BURIAL, Aug 6, 1920

20-UNDERTAKER Wm R A Elliott — ADDRESS

N. B.—Entries must be made in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42250 45419

REGISTERED NO. 14D 45419

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (W. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jake Goldstein

(a) RESIDENCE. NO. 1634 Lanvale St. Baltimore Md. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. 6/12 mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 2 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7 ~~8~~	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jos. Goldstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ethel Meister

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. H. Berends

15 Filed AUG 5, 1920 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1920

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1920, to Aug 5, 1920, that I last saw h. im alive on Aug 5, 1920, and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

DYSENTERY

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) NONE

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Parents Home

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Stool Culture

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Workmens Circle Mt Carmel

DATE OF BURIAL 8/5 1920

20 UNDERTAKER Jack Levis

ADDRESS 1411 E Balt

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 42290 D 45420

CERTIFICATE OF DEATH.

D 45420

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 5 WARD)

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Goldstein

(a) RESIDENCE. NO. 1200 E. Baltimore St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. unknown mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 25 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	22	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Typist

(b) General nature of Industry, business, or establishment in which employed (or employer): office

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Roumania

12 MAIDEN NAME OF MOTHER Esther Baitchman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. H. Bernds
(Address)

15 Filed AUG 5 1920 G. H. Gr... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 - 1920

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1920, to Aug 4, 1920
that I last saw h.e alive on Aug 4, 1920
and that death occurred, on the date stated above, at 11.45 p. m.
The CAUSE OF DEATH* was as follows:

Chronic nephritis with Uraemia.

(duration) 1 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) ____ yrs. 4 mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Blood urea + phthalein

(Signed) Ann Peril Pudd, M. D.

8/5, 1920 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem

DATE OF BURIAL: 8/5 19 20

20 UNDERTAKER: Jack Lewis

ADDRESS: 1411 E. Balt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations or terms on back of certificates. TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 45421

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45421

CERTIFICATE OF DEATH.

1920

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital St., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Cassidy.

(a) RESIDENCE. NO. 1415 E Hoffman ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 10 mos. 20 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If ~~married~~ widowed, ~~or divorced~~
HUSBAND of (or) WIFE of Mary Cassidy

6 DATE OF BIRTH (month, day, and year) Sept 14-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Mason

(b) General nature of industry, business, or establishment in which employed (or employer) 075

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Robt Cassidy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Cassidy
(Address) 1415 E Hoffman St.

15 Filed AUG 5 1920, 19 ... G. H. Gre... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 3, 11.30 a.m., 1920, to Aug 3, 4 P.M., 1920, that I last saw him alive on Aug 3, 1920, and that death occurred, on the date stated above, at 3.45 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) F C Malone, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cem. Govans	Aug. 6, 1920
20 UNDERTAKER	ADDRESS
Chas F. Ernst & Son	118 W. Mt. Royal ave

CAUSE OF DEATH in plain terms, so that it may be understood by the people generally. See instructions on back of certificates. TION is very important.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D45422

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45422

120

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 N. Port ST. 6 WARD)

2-FULL NAME Fredericka L. Lutz

(a) RESIDENCE. NO. 202 N. Port ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 60 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Chas. F. Lutz

6 DATE OF BIRTH (month, day, and year) Feb 3 - 45

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma Lutz
(Address) 202 N. Port

15 Filed AUG 5 1920 19 G. H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1919, to Aug 3, 1920

that I last saw h[illegible] alive on Aug 3rd, 1920.

and that death occurred, on the date stated above, at 10 05 A m.

The CAUSE OF DEATH* was as follows:

Uremia Coma

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John T Speckenagle M. D.

, 19 (Address) 104 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mathews	Aug 6 1920
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Aliceanna

CAUSE OF DEATH in plain terms, so that it may be properly classified. Use no abbreviations or terms of uncertain meaning. Do not report modes of dying, such as heart failure, asphyxia, etc., unless they are the only terms which can be reported. CONDITIONS THAT GIVE RISE TO THE IMMEDIATE CAUSE (a), (b), and (c), should be reported only if they are necessary to explain the sequence of the IMMEDIATE CAUSE. The CONTRIBUTORY CAUSE is often important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

845423

HEALTH DEPARTMENT—CITY OF BALTIMORE

845423

CERTIFICATE OF DEATH.

1042

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 Elm Str ST.: 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wieczystaw Tarnowski

(a) RESIDENCE. NO. 122 Ellen St ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 7 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Curtis Bay

PARENTS

10 NAME OF FATHER Anthony Tarnowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Alexandra Stamowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Anthony Tarnowski
(Address) 122 Ellen Str

15 Filed AUG 5 1920 C. H. Grieb Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 4 1920 to Aug 5 1920

that I last saw him alive on Aug 5 1920

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis

(Signed) Leon J. Horica, M. D.

Aug 5 1920 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	August 6 1920

20 UNDERTAKER ADDRESS

John M Weber 1809 Bank St

it may be properly classified. EXAMINE information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

D.45424 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45424

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 540 Baker ST.: 14 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Mathew Robinson

(Residence in Baltimore: No. 540 Baker St., St.; ...yrs., 3 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M.	C	Single

6-DATE OF BIRTH, April (Month) 27 (Day), 1920 (Year)

7-AGE, ...yrs. 3 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph M. Bell

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Alice Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Robinson

(Address) 540 Baker St.

15-

Filed AUG 5 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 4 (Day), 1920 (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 31 1920, to Aug. 4 1920, that I saw him alive on Aug. 4 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration)...yrs.....mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration)...yrs.....mos.....ds.

(Signed) John L. Sheppard M. D.

Aug. 4, 1920 (Address) 1502 W. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters	Aug 6, 1920
20-UNDERTAKER Edw. Kinggold	ADDRESS 1463 Carey St

CAUSE OF DEATH must be plainly written and all questions answered so far as possible. Omissions will cause delay. Every certificate must be complete and correct. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45425 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45425

CERTIFICATE OF DEATH.

15/2

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 Druid wood ave St.) 10 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Egan

(Residence in Baltimore: No. 1112 Druid wood ave St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Aug (Month) 4 (Day), 1920 (Year)

7-AGE, ...yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or 10 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jos. T. Egan

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Celia M Collins

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. T. Egan

(Address) 1112 Druid wood ave

15-

Filed ....., 191.... Registrar.

Robert P. Garrison,

AUG 6 1920 Burial Permit Clerk

CAUSE OF DEATH to print clear. important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 4 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 4 1920, to Aug 4 1920, that I saw h alive on Aug 4 1920, and that death occurred, on the date stated above, at 2.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Birth 3 hr.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. W. Thomas M. D.

Aug 5, 1920 (Address) 1278 W. Cary St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross

DATE OF BURIAL, Aug 4, 1920.

20-UNDERTAKER H. C. Hadfield

ADDRESS 917 Gruman-Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45426 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45426

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hokel or Hackel

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria-Hungary

PARENTS

10 NAME OF FATHER Nick Hokel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria-Hungary

12 MAIDEN NAME OF MOTHER Elizabeth Oxx

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria-Hungary

14 Informant Hospital Records, (Address) New City Hospital

15 Filed AUG 5 1920 Robert P. Warfield Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 1, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1920. to August 1. 1920.

that I last saw him alive on August 1, 1920.

and that death occurred, on the date stated above, at 11:50 P.m.

The CAUSE OF DEATH* was as follows:

Lung abscess over

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pyopneumothorax

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? X-rays.

(Signed) V. Bateman, M. D.

8/2/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF [redacted] CREMATION [redacted]	DATE OF BURIAL
Bay View Hospital	Aug 4 1920
20 UNDERTAKER J. B. Hunter	ADDRESS BIH

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

D.45427 HEALTH DEPARTMENT--CITY OF BALTIMORE D.45427

CERTIFICATE OF DEATH

151

1 PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 705 Roland Ave - Roland Park ST. 27 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Unnamed son of W. W. Smith

(Residence in Baltimore: No. St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Examine statement of OCCUPATION so that it may be properly classified. Examine statement of CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Aug (Month) 3 (Day), 1920 (Year)

7 AGE: 7½ mo premature — yrs. mos. ds. — If LESS than 1 day, hrs. or 15 min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country): Baltimore City (Md.)

PARENTS

10 NAME OF FATHER: William Wallace Smith

11 BIRTHPLACE OF FATHER (State or country): Mullon Pa

12 MAIDEN NAME OF MOTHER: Ruth B Den X

13 BIRTHPLACE OF MOTHER (State or country): Bloomsburg Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. W. Smith

(Address) 705 Roland Ave

15 Robert P. Harrison, JOHNS HOPKINS HOSPITAL

Filed AUG 5 1920 191 1740 Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug (Month) 3rd (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 8/3, 1920, to 8/3rd 1920, that I saw h[illegible] alive on 8/3rd, 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Prematurity

Lived 15 minutes

(Duration) yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Herman R Clarke M. D.

Aug 3, 1920 (Address) Roland Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. — In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: AUG 5 1920

20 UNDERTAKER: Commissioner Health. For, Wm. F. WOODALL — ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45428

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45428

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 525 S. Kenwood Ave. WARD 1)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick H. Berger

(a) RESIDENCE. No. 525 S. Kenwood Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hazel Berger

6 DATE OF BIRTH (month, day, and year) July 17, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Can Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Julius Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hazel Berger
(Address) 525 S. Kenwood Ave.

15 Filed AUG 5 1920 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1920

17 I HEREBY CERTIFY, That I attended deceased from July 9th, 1920, to Aug 3rd, 1920, that I last saw him alive on Aug 3rd, 1920, and that death occurred, on the date stated above, at 11 45 P.m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation
Heart

Indefinite (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Malignant Endocarditis

(duration) ... yrs. ... mos. 25 ds.

18 Where was disease contracted if not at place of death? Houston, Del.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood

(Signed) John Albert Miller, M. D.

(Address) 2739 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Aug 6 1920
20 UNDERTAKER H. Sander Sons	ADDRESS Broadway

Burial Permit Clerk

CAUSE OF DEATH must be plainly stated. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45429 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45429

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 317 So. 14th. ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Arnston Johannesen

(a) RESIDENCE. NO. 317 So. ~~East~~ 4th ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. 6 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 2 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md. Balto.
(State or country)

PARENTS

10 NAME OF FATHER Herb. A. Johannsen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Norway

12 MAIDEN NAME OF MOTHER Marie Brundesek

13 BIRTHPLACE OF MOTHER (city or town) Norway
(State or country)

14 Informant O.B. Fowler
(Address) 1432 William St

15 Robert F. Harrison,
Registrar

AUG 5 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 — 4 — 1920

17 I HEREBY CERTIFY, That I attended deceased from 8/3/20, 19..., to 8/4, 1920, that I last saw h... alive on 8/4, 1920, and that death occurred, on the date stated above, at 9.05 a. m.

The CAUSE OF DEATH* was as follows:

Acute Pleurisy

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical only

(Signed) Philip B. Fowler, M. D.

8/4, 1920 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Aug 6 1920
20 UNDERTAKER H. Sander Son	ADDRESS 1700 East

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.45430 50 D.45430

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lake Drive ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry S. Hecht.

(Residence in Baltimore: No. Alhambra Apts ST.; 57 yrs., 6 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (*Write* the word.)

6-DATE OF BIRTH, June (Month) 7 (Day), 1863 (Year)

7-AGE, 57 yrs. 6 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Wholesale Jewelry
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Simon Hecht

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Henrietta Stern

13-BIRTHPLACE OF MOTHER (State or Country), Germany,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Henry S. Hecht

(Address) Alhambra Apts

15- AUG 5 1920, 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 5 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1914, to Aug 5 1920, that I saw h~~im~~er alive on Aug 4 1920, and that death occurred, on the date stated above, at 2.34 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Gangrene of Leg 6 mos)

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) yrs. mos. 1 ds.

(Signed) Arthur Reg Todd M. D.

Aug 6, 1920 (Address) 821 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Hebrew	Aug 6, 1920
20-UNDERTAKER	ADDRESS
J Ahrens & Co	1611 Mad Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.45431 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45431

CERTIFICATE OF DEATH. 50

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Helen Katzenberg

(a) RESIDENCE. NO. 463 N. Gay ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? Life yrs. mos ds

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 10, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Max Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Seldner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hosp. Records (Address)

15 Filed AUG 5 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5 1920

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1920, to Aug. 5, 1920, that I last saw h[er] alive on Aug. 16, 1920, and that death occurred, on the date stated above, at 12.15 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene of left leg (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7/21/20

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thomas L. Ridgely, M. D.

8/6, 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew	Aug 9 1920
20 UNDERTAKER	ADDRESS
J Ahrens & Co	1611 Mad

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45432 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45432

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S. Stricker ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME LeRoy Frost

(a) RESIDENCE. No. 319 S. Stricker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Dec 3, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		8	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Jennie Frost

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ✓

14 Informant: Mrs Ziegler

(Address) 319 S. Stricker St

15 Filed AUG 5 1920 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1920

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1920, to Aug 3, 1920, that I last saw him alive on Aug 3, 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Enterocolitis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Marasmus ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) M. A. O'Neill M. D.

8/4, 1920 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem Balto	Aug 5 1920
20 UNDERTAKER	ADDRESS
Mrs Mrs A. S. Stinch	2651 Pennsylvania

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.45433

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45433

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Stone House Cove ST.; 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank P. Anderson

(a) RESIDENCE. No. Stone House Cove ST., WARD. 25

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 11 mos. 21 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	wh	Widowed

5a If married, widowed, or ~~divorced~~ ~~HUSBAND of~~ ~~WIFE of~~ Louisa Anderson

6 DATE OF BIRTH (month, day, and year) Aug 15 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farming

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant James E Anderson

(Address) Stone House Cove

15 Filed AUG 5 1920 Robert P. Matthews, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 3 1920 to Aug 5 1920 that I last saw h... alive on Aug 5 1920 and that death occurred, on the date stated above, at 9.25 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) R.O. Johnson M. D.

, 19 (Address) Brooklyn.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
CEDAR HILL.	AUG 7 1920

20 UNDERTAKER	ADDRESS
JOHN F. DENNY	716 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45434 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45434

CERTIFICATE OF DEATH. 1320

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 W. Lombard St. ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Wuennenberg-Pfaff

(a) RESIDENCE. NO. 1819 W. Lombard St. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 24 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Buchenaner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Euker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Gertrude Wuennenberg
(Address) 1819 W. Lombard St.

15 Filed AUG 5 1920 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 3 1920

17 I HEREBY CERTIFY, That I attended deceased from may 20, 1920, to aug 2, 1920, that I last saw h[illegible] alive on aug 2, 1920, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Wally Alcorn, M. D.

8 4 1920 (Address) 524 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	8/6 1920
20 UNDERTAKER	ADDRESS
George A Farley	Fulton & Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45435 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45435

CERTIFICATE OF DEATH.

132

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hospital ST.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beulah May Holzer

(a) RESIDENCE. No. 2602 Jefferson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of (Husband of) William Charles Holzer

6 DATE OF BIRTH (month, day, and year) July 22, 1896

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
24	0	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lantz Maryland

PARENTS

10 NAME OF FATHER John Wagaman

11 BIRTHPLACE OF FATHER (city or town) Lantz (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bessie Brown

13 BIRTHPLACE OF MOTHER (city or town) Lantz (State or country) Maryland

14 Informant William Charles Holzer

(Address) 2602 Jefferson St.

Filed AUG 5 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) ~~July~~ Aug 4 1920

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1920, to July 4, 1920, that I last saw her alive on July 4, 1920, and that death occurred, on the date stated above, at 3.20 a m.

The CAUSE OF DEATH* was as follows:

Child birth - (followed by infection of pelvis)

(duration) 0 yrs. 0 mos. 14 ds.

CONTRIBUTORY (Secondary) Pelvic peritonitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? 2602 Jefferson St.

Did an operation precede death? Yes Date of Aug. 3, 1920

Was there an autopsy? No

What test confirmed diagnosis? Inspection during operation

(Signed) Howard Matthews Bubert, M. D.

, 19 (Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First Evangelical Elem	Aug 6 1920
20 UNDERTAKER	ADDRESS
Mrs C. Miller.	2334 Jeffers

CAUSE OF DEATH in plain terms, so that it may be properly classified. ...act statement of OCCUPATION is very important. See instructions on back of certificates.

D45436 D45436

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1042

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1443 Dennwalt Ct ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest W J Bentz

(a) RESIDENCE. No. 1443 Dennwalt Ct ST., WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~

6 DATE OF BIRTH (month, day, and year) April 3-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	1	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work notary

(b) General nature of industry, business, or establishment in which employed (or employer) ~

(c) Name of employer ~

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ernst R Bentz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER May E Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Ernst R Bentz

(Address) 1443 Dennwalt St

15 Filed ..... 19.....

AUG 6 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/5 1920

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1920, to Aug 5, 1920, that I last saw h.. alive on Aug 4, 1920, and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Gastric Enteritis

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? ~

(Signed) E E Winston, M. D.

8/5/1920 (Address) 301 East Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem

DATE OF BURIAL: 8/6 1920

20 UNDERTAKER: I. Few McCully

ADDRESS: 130 E. Fay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45437

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D 45437

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 13 So. Calhoun ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A Brown

(a) RESIDENCE. NO. 113 So Calhoun ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John T Brown

6 DATE OF BIRTH (month, day, and year): July 15 1843

7 AGE: Years 77 Months Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Nathan Hatfield

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Louisa Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Geo A Brown
(Address) 113 So Calhoun

15 Filed AUG 6 1920 19 C H Cross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 4 1920

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1920, to Aug 4, 1920, that I last saw her alive on Aug 4, 1920, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Urinary Exam.

(Signed) E Wells Fleming M. D.

8/5, 1920 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Aug. 6 1920

20 UNDERTAKER: Wm Cook — ADDRESS: N + G Mts.

mation should be carefully supplied. All items should be answered. Exact statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45438

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45438

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1608 N Calhoun ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Conrad Korber

(a) RESIDENCE. No. 1608 N Calhoun ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Wht

5 ~~Single, Married~~, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 29 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	11	~~7~~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerical work

(b) General nature of industry, business, or establishment in which employed (or employer): Dry Goods

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Christian F. Korber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger

12 MAIDEN NAME OF MOTHER: Eliz. Kooby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger

14 Informant: Mrs Wm Means
(Address) 1608 N Calhoun St

15 Filed AUG 6 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1920

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1920, to Aug. 5, 1920, that I last saw him alive on Aug. 4, 1920 and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Acute Meningitis
Fro Lues

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart Dis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Jacksonville Florida

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wasserman

(Signed) E. H. Lewis M. D.

Aug 5, 1920 (Address) 1608 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Aug 7 1920

20 UNDERTAKER: Wm. Cook. — ADDRESS: 502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Special 5-20-20-M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45439

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 917 N. Eden St ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margarette B. Mueller

(Residence in Baltimore: No. 917 N. Eden St. St.; 64 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, April (Month) 12 (Day), 1852 (Year)

7-AGE. 68 yrs. 3 mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Edward Riehl.

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER Annie Greifenstein

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Christopher Mueller

(Address) 917 N. Eden St

15- Filed AUG 6 1920, 191..... G. H. Creye Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 4 (Month) (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 16 1920, to Aug. 4 1920, that I saw her alive on Aug 3 1920, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonal Tuberculosis

(Duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. C. Sandbeck M. D.

Aug. 5, 1920. (Address) 1242 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cem. DATE OF BURIAL, Aug 7, 1920

20-UNDERTAKER Frank A. Fink ADDRESS 935 E. Lay

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-2-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~9452440~~ 454440 ~~32~~

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital Lombard & Greene Sts. ST.; 9 WARD)

2-FULL NAME James Connell

(a) RESIDENCE. NO. 1473 Homestead St. Md. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) December 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31 years	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: optician

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Homestead Md

PARENTS

10 NAME OF FATHER James Connell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Homestead, Md.

12 MAIDEN NAME OF MOTHER Mary Gay

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant Mrs. Edward Connell
(Address) 1473 Homestead St —

15 Filed AUG 6 1920 G. H. C... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1920

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1920, to Aug 5, 1920

that I last saw him alive on Aug 5, 1920

and that death occurred, on the date stated above, at 4.55 a m.

The CAUSE OF DEATH* was as follows:

Pott's disease, complicated by large lumbar abscess

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) amyloid degeneration of viscera cardiac failure oedema of lungs (duration) 4 days yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? ...

(Signed) ... M. D.

8/5, 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem.	Aug 7th 1920
20 UNDERTAKER	ADDRESS
John J Cowan & Son	901 Gallows St

mation should be carefully supplied. AGE, should be stated in YEARS, MONTHS and DAYS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45441

HEALTH DEPARTMENT—CITY OF BALTIMORE

170 D 45441

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 325 S. Monroe ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad G. Rapp

(a) RESIDENCE. No. 325 S. Monroe ST., 19 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 9 mos. 3 ds. How long in U. S., if of foreign birth? yrs mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Emma Rapp

6 DATE OF BIRTH (month, day, and year) Oct 1st 18-1859.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	10	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Conrad Rapp.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mary E. Keller
(Address) 22 S. Woodyear St.

15 Filed AUG 6 1920

C. H. Grock Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1920, to Aug 3, 1920

that I last saw him alive on Aug 3, 1920

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Wm. Hamman M. D.

Aug 4 1920 (Address) 835 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 6th 1920
20 UNDERTAKER	ADDRESS
John J Cowan & Son	901 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45442 ✓ D45442

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. Annapolis Road ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose L. Wallerman

(Residence in Baltimore: No. Annapolis Road West Port St.: Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, 9 (Month) 12 (Day), 1877. (Year)

7-AGE, 42 yrs. 10 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Saloon Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): Office

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Wm H Arnold

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Kennetta L Bonner

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas L Fisher Wallerman

(Address) West Port city

15-

Filed AUG 6 1920 191 C. H. Grese Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 4 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1920., to Aug 4 1920, that I saw h-r alive on July 4 1920, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Tetanus

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration) ..... yrs. 1 mos. 20 ds.

(Signed) Thos B. Keech M. D.

8-5, 1920 (Address) Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Cedar Hill Cem — DATE OF BURIAL, Aug 6, 1920

20-UNDERTAKER W. J. Tickner & Sons — ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

D45443 HEALTH DEPARTMENT—CITY OF BALTIMORE. D45443

CERTIFICATE OF DEATH.

174

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Elevator "B" Locust Point St.: 21 WARD) REGISTERED No. C

2-FULL NAME William C.Riley

(Residence in Baltimore: No. 813 Scott St.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

50 St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH. August 12th. 1864, 1 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
55 yrs. 10 mos. 22 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Spoutman in
(b) General nature of industry, business, or establishment in which employed (or employer)..... grain elevator.

9-BIRTHPLACE, (State or Country), Brooklyn A.A.Co.Md.

PARENTS.

10-NAME OF FATHER, George Riley.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Mary Jones.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Riley.(wife)

(Address) 813 Scott St.

15- Filed AUG 6 1920 191 G. H. Grese. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 3rd. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the Skull.
Accidentally mangled about the head and body in a pulley.

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) H. W. Bernhardt (Coroner) M. D.

Aug 5 1920. (Address) 1017 S.Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Greenden Park

DATE OF BURIAL, aug 6 1920

20-UNDERTAKER W.J. Pokrefsen

ADDRESS north Ave

N. B.—Every item of information should be carefully supplied. AGE must be given. Information is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45444 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45444

CERTIFICATE OF DEATH. 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2622 Harford ST. Dav 9 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael J Magann.

(a) RESIDENCE. No. Maryland Cathedral Hospital ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) July 17/1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	—	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Paper Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt md

PARENTS

10 NAME OF FATHER H. Magann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Buckley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland Md.

14 Informant Mrs Ella Magann (Address) 2622 Harford Ave.

15 Filed AUG 6 1920 19 G. H. G... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3rd 1920

17 I HEREBY CERTIFY, That I attended deceased from July 31 , 1920 , to Aug. 3, , 1920 , that I last saw him alive on Aug 3 , 1920 , and that death occurred, on the date stated above, at 4.20 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation (Acute)

(duration) yrs. mos. — ds.

CONTRIBUTORY (Secondary) Pneumonia following Operation for Strangulated Hernia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 31, 20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. F. Hoy Tompkins M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug. 7th 1920
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

142 332 D 45445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45445

CERTIFICATE OF DEATH.

104-09

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 19th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Dowkus.

(a) RESIDENCE. NO. 528 Fulton Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 31. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Dowkus.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania.

12 MAIDEN NAME OF MOTHER Mary Paulus.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) J. HH. Rennds

15 Filed AUG 6 1920 G. H. Greene Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5. 1920

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1920, to Aug 5, 1920, that I last saw h.r alive on Aug 5, 1920, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia - bronchs

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Cuba, Long

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical diagnosis

(Signed) Wm Stahl, M. D.

, 19 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug. 7 1920

20 UNDERTAKER George J. Ruth ADDRESS 1735 Hanford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 45446 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 91 D 45446

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1751 Eliptview ST.; 8 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Dinter Hoeschele

(Residence in Baltimore: No. 1751 Eliptview St.; = yrs., 1 mos. 14 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. June 21st, 1920 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
0 yrs. 1 mos. 14 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ealy

PARENTS.

10-NAME OF FATHER Herman Hoeschele

11-BIRTHPLACE OF FATHER (State or Country), Ealy

12-MAIDEN NAME OF MOTHER Mildred R. Davis

13-BIRTHPLACE OF MOTHER (State or Country), Ealy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman Hoeschele

(Address) 1751 Eliptview

15- Filed AUG 6 1920, 191.... C. H. Greve Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 4th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1st. 1920, to Aug 4 1920, that I saw h[im] alive on Aug 4 1920 and that death occurred, on the date stated above, at 840 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. N. Meyer Jr. M. D.

Aug 5, 1920. (Address) 1638 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs. ....mos. ....ds. In the State....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Aug. 6, 1920
20-UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson

Spec.—8-24-14—M. & T.—2000 Bks.

D 45447

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D 45447

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Chas. Gokey

(Residence in Baltimore: No. 1223 Madison ave St.; Wh yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Dec. (Month) 25th (Day), 1919 (Year)

7-AGE, ...yrs. 7 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm. C. Gokey

11-BIRTHPLACE OF FATHER (State or Country), Canada

12-MAIDEN NAME OF MOTHER Esther Schultz

13-BIRTHPLACE OF MOTHER (State or Country), New Jersey

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Records

(Address) .....

15- Filed AUG 6 1920, 191 S. H. Grese. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 6th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 29th 1920, to Aug. 6th 1920, that I saw him alive on Aug. 6th 1920, and that death occurred, on the date stated above, at 6:20 A. m.

The CAUSE OF DEATH* was as follows:

.....Ileo Colitis.....

.....

..... (Duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Wm. Jacks M. D.

Aug. 6, 1920 (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 8 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence 1223 Madison Ave

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship — DATE OF BURIAL, Aug. 8, 1920

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of fact important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45448 HEALTH DEPARTMENT—CITY OF BALTIMORE D45448.

114

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paulina Glazer

(a) RESIDENCE. NO. 1809 E. Pratt ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs mos. ds.

(If nonresident give city or town and State)

be stated EXACTLY. PHYSICIANS should be careful to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Hyman Glazer

6 DATE OF BIRTH (month, day, and year): 1870

7 AGE: Years 53 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): S. Lewis 1411 E. Baltimore St

15 Filed AUG 6 1920 C. H. Cross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 5, 1920

17 I HEREBY CERTIFY, That I attended deceased from August 4, 1920, to August 5, 1920, that I last saw her alive on August 5, 1920, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Acute Exacerbation of Chronic Cholelithiasis causing symptoms of intestinal obstruction (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) "Shock" (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Israel J. Kaplan M. D.

, 19 (Address) 2602 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 9/6 1920

20 UNDERTAKER: Jacob Lewis

ADDRESS: 1411 E. Balto

Spec.—8-24-14—M. & T.—2000 Bks.

D 45449 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45449

CERTIFICATE OF DEATH. 1920

1-PLACE OF DEATH Woman's Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Lafayette & John Sts. ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Reid

(Residence in Baltimore: No. 6 Beechdale Rd R P St.: ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	White	Single

6-DATE OF BIRTH, ... Aug. (Month) ..... 5 (Day), 1920. (Year)

7-AGE, 4hrs - 40 min ..... 0 yrs. ..... 0 mos. ..... 0 ds.

If LESS than 1 day, 4 hrs. or 40 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... 0 ..... gtd.
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Woman's Hospital Baltimore Md.

PARENTS.

10-NAME OF FATHER, William C. Reid

11-BIRTHPLACE OF FATHER (State or Country) North Carolina

12-MAIDEN NAME OF MOTHER Sadie Evelyn Clayton

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Woman's Hospital

(Address) ..... Lafayette & John St

15-

Filed AUG 6 1920 191..... H. Grese. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug. (Month) ..... 5 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I saw him alive on Aug. 5 1920, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature Infant

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... R. M. Wilson ..... M. D.

Aug. 5, 1920 (Address) 1212 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 4hrs ds. In the State 0 yrs. 0 mos. 4hrs ds.

Where was disease contracted, if not at place of death? ? ?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery — DATE OF BURIAL, Aug. 6, 1920

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) — ADDRESS 108 W. NORTH A...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Last sickness of deceased should be given. Indefinite terms, such as "Heart Failure," "Exhaustion," "Old Age," "Infirmities," "Natural Causes," "Pneumonia," "Tuberculosis," "Cancer," "Stroke," "Fever," "Septicemia," "Blood Poisoning," "Abscess," "Gangrene," "Convulsions," "Uremia," "Meningitis," "Hemorrhage," "Dropsy," "Debility," "Senility," "Marasmus," "Malignant Disease," "Tumor," "Accident," "Suicide," "Homicide," "Drowning," "Burns," "Fracture," "Concussion," "Internal Injuries," "Shock," "Asphyxia," "Poisoning," "Unknown," "Unascertained," "Found Dead," "Not Known," "Not Stated," "Not Given," "Not Ascertained," "Not Known How Long," "Not Known How Long Ill," "Not Known How Long Sick," "Not Known How Long Dead," "Not Known How Long Missing," "Not Known How Long Lost," "Not Known How Long Gone," "Not Known How Long Absent," "Not Known How Long Away," "Not Known How Long Abroad," "Not Known How Long Overseas," "Not Known How Long Ago," "Not Known How Long Since," "Not Known How Long Before," "Not Known How Long After," "Not Known How Long Between," "Not Known How Long During," "Not Known How Long While," "Not Known How Long Whilst," "Not Known How Long Whereas," "Not Known How Long Whereby," "Not Known How Long Wherein," "Not Known How Long Whereof," "Not Known How Long Whereon," "Not Known How Long Whereto," "Not Known How Long Wherewith," "Not Known How Long Wherewithal," "Not Known How Long Whereunto," "Not Known How Long Whereupon," "Not Known How Long Wherever," "Not Known How Long Whether," "Not Known How Long Which," "Not Known How Long Whichever," "Not Known How Long Whichsoever," "Not Known How Long Whilst," "Not Known How Long Whiles," "Not Known How Long Whilom," "Not Known How Long Whither," "Not Known How Long Whithersoever," "Not Known How Long Whitherto," "Not Known How Long Whitherunto," "Not Known How Long Whitherwards," "Not Known How Long Who," "Not Known How Long Whoever," "Not Known How Long Whole," "Not Known How Long Wholly," "Not Known How Long Whom," "Not Known How Long Whomever," "Not Known How Long Whomsoever," "Not Known How Long Whose," "Not Known How Long Whosesoever," "Not Known How Long Why," "Not Known How Long Wide," "Not Known How Long Widely," "Not Known How Long Wider," "Not Known How Long Widest," "Not Known How Long Width," "Not Known How Long Wife," "Not Known How Long Wild," "Not Known How Long Wilder," "Not Known How Long Wildest," "Not Known How Long Wilderness," "Not Known How Long Wildly," "Not Known How Long Will," "Not Known How Long Willful," "Not Known How Long Willfully," "Not Known How Long Willing," "Not Known How Long Willingly," "Not Known How Long Willingness," "Not Known How Long Willow," "Not Known How Long Willowy," "Not Known How Long Wilt," "Not Known How Long Wily," "Not Known How Long Win," "Not Known How Long Wind," "Not Known How Long Windy," "Not Known How Long Wine," "Not Known How Long Wing," "Not Known How Long Winged," "Not Known How Long Winter," "Not Known How Long Wintry," "Not Known How Long Wipe," "Not Known How Long Wire," "Not Known How Long Wiry," "Not Known How Long Wisdom," "Not Known How Long Wise," "Not Known How Long Wisely," "Not Known How Long Wish," "Not Known How Long Wishful," "Not Known How Long Wishfully," "Not Known How Long Wishing," "Not Known How Long Wishingly," "Not Known How Long Wit," "Not Known How Long Witch," "Not Known How Long Witchcraft," "Not Known How Long With," "Not Known How Long Withal," "Not Known How Long Withdraw," "Not Known How Long Withdrawal," "Not Known How Long Withdrawn," "Not Known How Long Withe," "Not Known How Long Wither," "Not Known How Long Withered," "Not Known How Long Withering," "Not Known How Long Withers," "Not Known How Long Withheld," "Not Known How Long Within," "Not Known How Long Without," "Not Known How Long Withstand," "Not Known How Long Withstood," "Not Known How Long Witness," "Not Known How Long Witnessed," "Not Known How Long Witnessing," "Not Known How Long Witnesses," "Not Known How Long Witnessing," "Not Known How Long Witnessing," "Not Known How Long Witnessing

D45450 HEALTH DEPARTMENT—CITY OF BALTIMORE D45450

CERTIFICATE OF DEATH.

79

(PLACE OF DEATH

CITY OF BALTIMORE (No. 1240 James ST.: 21 WARD) REGISTERED No. C

2-FULL NAME Jonzbo Skrupkunas

(Residence in Baltimore: No. 1240 James St.: yrs., 15 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, X ....., 1866
(Month) (Day) (Year)

7-AGE, 54 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Lithuania

PARENTS.

X 10-NAME OF FATHER, Not known

X 11-BIRTHPLACE OF FATHER (State or Country), Lithuania

X 12-MAIDEN NAME OF MOTHER Not known

X 13-BIRTHPLACE OF MOTHER (State or Country), Lithuania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Letkauski

(Address) 1240 James St.

15- Filed AUG 6 1920, 191 G. H. Cree Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 5, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart Sudden

(Duration) yrs. mos. ds.

(Signed) James W Fenton M. D.
(Coroner.)

Aug 5 1920 (Address) 1012 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Aug 7 1920
20-UNDERTAKER	ADDRESS
John Grebliunckus	425 S. Paca St.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION (see No. 8) is important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

045451 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 045451

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Franklin Sq. Hospital St.: 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hom Chung

(a) RESIDENCE. No. 328 Park ave St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Yellow	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dont Know

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laundry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) China

PARENTS

10 NAME OF FATHER Hom Mon Hing

11 BIRTHPLACE OF FATHER (city or town) (State or country) China

12 MAIDEN NAME OF MOTHER Wong Shee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) China

14 Informant Chin Quon

(Address) 114 Park ave

15 Filed AUG 6 1920 G. H. Grose Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 5, 1920

17 I HEREBY CERTIFY, That I attended deceased from aug 1, 1920, to aug 5, 1920

that I last saw h/m alive on aug 5, 1920,

and that death occurred, on the date stated above, at 3.45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hyman S abbott, M. D.

, 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Aug 9 1920
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette

MAKE ENTRIES WITH PEN AND INK. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 lks.

D 45452 ✓ D 45452

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45452 Sanphilippo Sanphilippo

CERTIFICATE OF DEATH.

REGISTERED NO. C 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST. 1 WARD) 19

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr. Michael Sanfelippo. 29

(Residence in Baltimore: No. 408 N. Pearl St.; 56 yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug. (Month) 25 (Day), 1864 (Year)

7-AGE, 56 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fruit dealer
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Joseph Sanfelippo

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rosa Mufutalio

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Aguilla

(Address) 638 W. Mulberry

15-

Filed AUG 6 1920 191 G. H. Grese Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 5 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 26 1920, to Aug 5 1920, that I saw him alive on Aug 5 1920, and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Intracranial Teratoma

(Duration) yrs. 6 mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) A. N. Jannenbaum M. D.

Aug 5, 1920 (Address) U. M. H.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 10 ds. In the State 20 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 408 Pearl St Balto Md

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Aug 7, 1920

20-UNDERTAKER John C. Mitchell — ADDRESS 1201 W. Fayette

R. C. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact attention to this is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45453

D 45453

CERTIFICATE OF DEATH.

X 45

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Strange

(a) RESIDENCE. NO. 1504 N Liberty St. Winston-Salem N.C. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Minnie Strange

6 DATE OF BIRTH (month, day, and year) Jan 1870 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cafe.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Albert Strange.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lizzie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant J. H. H. Reeves
(Address)

15 Filed AUG 6 1920 G. H. Grose Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1920, to Aug 5, 1920, that I last saw h. alive on Aug 5, 1920, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Heart failure, Carcinoma of Larynx, Laryngeal obstruction

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Laryngeal stenosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? N.C.

Did an operation precede death? Yes Date of 8-5-20

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopical

(Signed) Prof. Lenhartz, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Winston Salem N. C.	Aug 6 20
20 UNDERTAKER	ADDRESS
H E Hughes	417 S Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45454

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45454

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 319 S. 13th (St.) (Ward) 76

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Martin Carroll

(a) RESIDENCE. No. 319 S. 13th — St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~or WIFE of~~ Margaret M. Carroll

6 DATE OF BIRTH (month, day, and year) July 4th 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	1	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Car Inspector
(b) General nature of industry, business, or establishment in which employed (or employer): 073
(c) Name of employer: P. P. R.R.

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Margaret M Carroll
(Address): 319 S 13th St

15 Filed: AUG 6 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1920

17 I HEREBY CERTIFY, That I attended deceased from July 15 1920 to Aug 5 1920, that I last saw h— alive on Aug 4 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Neoplasm of Bladder
(Prostate, Carcinoma)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hydronephrosis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic exam.

(Signed) Walter W White Jr. M. D.

8/6 1920 (Address) 2800 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 7 1920
20 UNDERTAKER	ADDRESS
Zirkler & Zirkler	1239 Eager

mation should be carefully supplied. AGE should be properly classified. Exact statement of the OCCUPATION that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of the OCCUPATION is very important. See instructions on back of certificates.

D 45455

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

91 D 45455

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 W. 30th St.: 15th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John L. Hale

(Residence in Baltimore: No. 313 W. 30th St.; yrs. 21 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	W	—

6-DATE OF BIRTH 5/15 (Month) (Day), 1899 (Year)

7-AGE 21 yrs. 2 mos. ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) Odd

9-BIRTHPLACE (State or country) above

PARENTS

10-NAME OF FATHER John J. Hale

11-BIRTHPLACE OF FATHER (State or country) Md

12-MAIDEN NAME OF MOTHER Mae Burke

13-BIRTHPLACE OF MOTHER (State or country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. J. Hale

(Address) above

15- AUG 6 1920 Robert P. Harrison, Registrar

Burial Permit; Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 8/5 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 7/27, 1920, to, 8/5 1920, that I saw h[illegible] alive on 8/5 1920, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. ds.

Contributory (SECONDARY) (Influenza) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Henry F. Carey M. D.

8/6, 1920 [Address] Roland Pk

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Cathedral — DATE OF BURIAL Aug 7, 1920

20-UNDERTAKER Martin Fahey & Sons — ADDRESS 827 N. Paca St.

N. B.—Every item of information should be carefully supplied. AGE must be stated. Exact statement of OCCUPATION should be given, so that it may be properly classified. See instructions on back of certificate.

D.45456

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45456 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

33

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Shiflett

(a) RESIDENCE. No. unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Charles Shiflett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed AUG 6 1920, 19.. [illegible] Registrar

[illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 3, 1920

17 I HEREBY CERTIFY, That I attended deceased from March 24, 19 20 to August 3, 19 20

that I last saw him alive on August 2, 19 20

and that death occurred, on the date stated above, at 12:30A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Knee joint

(duration) yrs. 5½ mos. ds.

CONTRIBUTORY (Secondary) Miliary T. Bacilli

T.B. of Kidney (duration) yrs. ½ mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of June 4/1920

Was there an autopsy? not as yet

What test confirmed diagnosis? microscopic

(Signed) F. A. Holden M. D.

8-3- 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: AUG 8 1920

20 UNDERTAKER: Commissioner Health

ADDRESS

Wm. E. WOODALL

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D.45457 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45457

CERTIFICATE OF DEATH.

175-001

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Gardner Drayer

(Residence in Baltimore: No. 910 Ensor St.)

(If under 1 year, 7 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, July (Month) 15 (Day), 1911 (Year)

7-AGE, 9 yrs. mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Washington D. C.

PARENTS.

10-NAME OF FATHER, Harry Drayer

11-BIRTHPLACE OF FATHER (State or Country), Washington D. C.

12-MAIDEN NAME OF MOTHER Louise Gardner

13-BIRTHPLACE OF MOTHER (State or Country) Washington D. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. H. E. Lehman

(Address) 1719 Newton St. Baltimore Md.

15-

Filed AUG 6 1920, 191.

Robert P. Harrison, Registrar.

Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Aug (Month) 6 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Lob

by Influenza

(Duration) yrs. mon. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mon. ds.

(Signed) Wm Lucy M. D.
(Coroner.)

8-6, 1920 (Address) 5 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 910 Ensor St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Washington D C	Aug 6, 1920
20-UNDERTAKER Henry Koech Son	ADDRESS 1301 E Eager St

Spec.—8-24-14—M. & T.—2000 Bks.

Sjoholm

D.45458

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45458

CERTIFICATE OF DEATH.

109 v

1-PLACE OF DEATH Womans Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Anna Sjoholm

(Residence in Baltimore: No. 36 W. Biddle St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR ~~DIVORCED~~, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) Unknown (Day) 1 (Year) .....

7-AGE (about) 29 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Home Maid
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Sweden

PARENTS.

10-NAME OF FATHER, Dont Known

11-BIRTHPLACE OF FATHER (State or Country), Sweden

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Sweden

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J Swan

(Address) 36 W Biddle St

15- Robert P. Harrison,

Filed ..... 191.....

AUG 6 1920 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 5 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 4 1920, to Aug 5 1920, that I saw her alive on Aug 5 1920, and that death occurred, on the date stated above, at 10:30 p m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction with gangrenous intestine

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Operation - Intestinal Resection (Duration) ..... yrs. 1 mos. 13 mo ds.

(Signed) James A Speed M. D.

Aug 5., 1920 (Address) Womans Hospt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Home-36 W. Biddle

Former or usual residence 36 W. Biddle

19-PLACE OF BURIAL OR REMOVAL, Old St Paul Cemetery

DATE OF BURIAL, Aug. 7., 1920

20-UNDERTAKER A N Jenkins Sons Co

ADDRESS Dulaney & Mt Royal Ave

N.B.—Every item of information must be given, so that it may be properly classified. Exact statement of occupation is important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45459 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45459

CERTIFICATE OF DEATH. 91-076

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 19 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Ziegler

(a) RESIDENCE. NO. 319 S. Stricker St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible] 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	13	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none.

(c) Name of employer none.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles E Ziegler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila. Pa

12 MAIDEN NAME OF MOTHER Katherine Hagengast

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Catherine Ziegler
(Address) 319 S Stricker St

15 Filed AUG 6 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1920, to Aug 4, 1920, that I last saw her alive on Aug 4, 1920, and that death occurred, on the date stated above, at 3.50 p.m.

The CAUSE OF DEATH* was as follows:

OPW

Broncho pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Purulent otitis media

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) J. D. Ridgley, M. D

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Cathedral Cem.	Aug 7 1920
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Kenyon Ave

Information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 45460

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45460

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 Eutaw Place ST.: 14 WARD)

2-FULL NAME William H. Gardenburg

(a) RESIDENCE. NO. 1700 Eutaw Place ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary L. Gardenburg

6 DATE OF BIRTH (month, day, and year): July 4 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): School Teacher

(c) Name of employer: Baltimore

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. D. Sellers

(Address): 1916 Mt. Royal Terrace

15 Filed AUG 8 1920 Robert P. Harrison, Registrar

Dr. Heiner Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 4 - 1920. to Aug. 5 - 1920.

that I last saw h.. alive on Aug. 4 - 1920.

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

about 3 yrs. — mos. — ds.
(duration)

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis

about 2 yrs. — mos. — ds.
(duration)

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of — (over)

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) J. Bond Hoiner M. D.

19 (Address) 2125 Maryland Ave

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug 7 1920
20 UNDERTAKER	ADDRESS
W. M. Cook	502 E. North Ave

mation should be carefully supplied. Avoid abbreviations, so that it may be properly classified. Exact statements are required. Do not use OCCUPATION or CAUSE OF DEATH in plain terms

Spec.—8-24-14—M. & T.—2000 Bks.

D245461

HEALTH DEPARTMENT—CITY OF BALTIMORE

D245461

CERTIFICATE OF DEATH.

64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2647 Hamsden Ave St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Athins

(Residence in Baltimore: No. 2647 Hamsden Ave St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Jan 28, 1854. (Month) (Day) (Year)

7-AGE, 66 yrs. 6 mos. 8 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), N. C

PARENTS.

10-NAME OF FATHER, John R. Little

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Nancy Crowder

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Susan Hertle

(Address) 2647 Hamsden Ave

15- AUG 6 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 5, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 10 1920, to Aug 5 1920, that I saw her alive on Aug 5 1920, and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ..... yrs. ..... mos. 26 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C A Dietrich Dr M. D.

Aug 6 1920 (Address) 1120 N. Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Mary's Hamsden | DATE OF BURIAL, Aug 7, 1920

20-UNDERTAKER A S Mc Donald Hall | ADDRESS 2339 Fall Rd

N.B.—Every item of information should be given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

D.45462 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45462

CERTIFICATE OF DEATH.

103

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2233 Huntingdon Ave ST. 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Pasquache

(Residence in Baltimore: No. 2233 Huntingdon Ave St.; yrs., 14 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Feb 16, 1907 (Month) (Day) (Year)

7-AGE, 13 yrs. 5 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Daniel Pasquache

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rose LeRose

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Pasquache

(Address) 2233 Huntingdon Ave

15- Filed AUG 6 1920, 191.... Robert P. Harrison, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 5, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Due to Intoxication

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) John H. Morrissey M. D. (Coroner.)

Dec 6, 1920 (Address) 2362 R. Route

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
St Vincents	Aug 7, 1920
20-UNDERTAKER	ADDRESS
A S Marshall	3539 Fall Rd

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45463

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45463

CERTIFICATE OF DEATH.

X 15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST.; 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johnson Brown

(Residence in Baltimore: No. 606 Jasper St. St.; ... yrs. 3 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Not known (Month) (Day) 1881. (Year)

7-AGE, 39 yrs. ... mos. ... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Sailor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Not known Va

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johnson Brown

(Address) 606 Jasper st

15-

Filed ..... 191.....

Robert P. Harrison, Registrar.

AUG 5 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 3rd (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 30 1920, to Aug 3rd 1920, that I saw him alive on Aug 3rd 1920, and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Lyfloid Fever

(Duration) ... yrs. ... mos. 21 ds.

CONTRIBUTORY (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) Harry T. Brown M. D.

Aug 4. 1920 (Address) 1501 Pressman st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ... yrs. 5 mos. ... ds. In the State ... yrs. 3 mos. ... ds.

Where was disease contracted, if not at place of death? Not known

Former or usual residence New Port News. Va

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Aug 5, 1920

20-UNDERTAKER Brown & Ireland

ADDRESS 1140 W. Lafayette

N.B.—Every item of information must be given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45464

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45464

CERTIFICATE OF DEATH.

108 V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 Balto Hook ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard J. Shewbridge

(a) RESIDENCE. NO. 1539 Marshall ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 3 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May 6 1900

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
20	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bikemaker 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Pearl H. Shewbridge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Annie E. Frame

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs H. Shewbridge

(Address) 1539 Marshall St.

15 Filed AUG 6 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1920

17 I HEREBY CERTIFY, That I attended deceased from 7-31- 1920, to Aug. 3, 1920, that I last saw him alive on Aug 3, 1920, and that death occurred, on the date stated above, at 11.20 P m.

The CAUSE OF DEATH* was as follows:

Appendicitis.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Peritonitis, volvulus.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7-31,20

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. F. Ponte Jr. M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedarhill Cem	8/7 1920
20 UNDERTAKER J. F. Hafey & Son	ADDRESS 1318 E. Fayette St

AUG 6 1920

mation should be carefully supplied. AGE should be stated EXACTLY. Incorrect statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D.45465 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45465

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1137 Battery ave ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Linnerman

(Residence in Baltimore: No. 1137 Battery ave St.; 32 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ..., (Month) (Day) 1858 (Year)

7-AGE, 62 yrs. mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Hungary

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Hungary

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Hungary

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Bradshaw

(Address) 1137 Battery ave

15- AUG 6 1920 Robert P. Harrison, Registrar.
Buried....., 191..... Burial Permit Cle

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 4, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 3 1920, to Aug 5 1920, that I saw h[illegible] alive on Aug 5 1920, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic & Mitral Insuff

(Duration) yrs. mos. ds.

(Signed) Nathan [illegible] M. D.

Aug 6, 1920 (Address) 1107 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Pet Cypress & Co. DATE OF BURIAL, 8/7, 1920

20-UNDERTAKER [illegible] Valley Lane ADDRESS 10 Light St

N.B.—Every item of information should be carefully noted, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45466

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45466

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hilsdale St. 28 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth M. Tyson

(Residence in Baltimore: No. Hilsdale St.; 50 yrs. ..... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED.~~ (Write the word.) Widowed

6-DATE OF BIRTH, March (Month) 2 (Day), 1835 (Year)

7-AGE, 85 yrs. 5 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

8-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), not known

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. B. Tyson

(Address) 1822 Edmondson Ave.

15-

AUG 6 1920

Robert E. Garrison, 191...

Registrar.

Field Health Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Aug (Month) 5 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1916, to Aug 5 1920, that I saw h.r alive on Aug 5 1920, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis — myocarditis

Chronic interstitial nephritis

..... (Duration) 9 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) myocarditis — arteriosclerosis nephritis

..... (Duration) ? yrs. ..... mos. ..... ds.

(Signed) W. S. Nibett M. D.

Aug 6/20, 191... (Address) 3402 Clifton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Westlakeley Cem

DATE OF BURIAL, Aug 8., 192[illegible]

20-UNDERTAKER E. L. Stiffler

ADDRESS 1242 North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45467

D45467

CERTIFICATE OF DEATH.

8V

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1235 S. Decker Av ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Kozmiowski

(a) RESIDENCE. NO. 1235 S Decker av ST., 1 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. — mos. — How long in U. S., if of foreign birth? — yrs. — mos. — (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 16-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Wladyslaw Kozemiostki

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country) Russia

12 MAIDEN NAME OF MOTHER Catherine Zakowska

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

11 Informant Wladyslaw Kozemiowski

(Address) 1235 S Decker av

Filed AUG 7 1920 19 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 2 1920, to Aug 6 1920, that I last saw h— alive on Aug 6 1920, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Grant M. D.

8/6/20 19 (Address) 801 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Aug 6 1920
20 UNDERTAKER	ADDRESS
Stephen Stalkowski	1000 S Kenwood Ave

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45468 HEALTH DEPARTMENT—CITY OF BALTIMORE D45468

82

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1516 Booth ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bruce

(a) RESIDENCE. NO. 1516 Booth ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriet Brooks

6 DATE OF BIRTH (month, day, and year) July 9-1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Gen'l at large

(c) Name of employer Balto

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Elizabeth Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Harriet Brooks (Address) 1516 Booth St

15 Filed AUG 7 1920 19 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 1920

17 I HEREBY CERTIFY, That I attended deceased from July 29th, 1920, to August 5th, 1920, that I last saw him alive on August 1st, 1920, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Multiple Hemorrhages

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General symptoms

(Signed) Howell D Cummins, M. D.

19 (Address) 1924 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Aug 7th 1920

20 UNDERTAKER A. Jones — ADDRESS 207 S. Stricker St

N. B.—Items should be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45469 HEALTH DEPARTMENT—CITY OF BALTIMORE D45469

CERTIFICATE OF DEATH. 1920

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 E. Lafayette Ave. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine A. VanDaniker

(a) RESIDENCE. No. 12 E. Lafayette Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 10" 1852

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Van Daniker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Elizabeth Bernard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Md.

14 Informant Leon R. Van Daniker
(Address) 12 E. Lafayette Ave

15 Filed 8-7 1920 G. H. Cress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4th 1920

17 I HEREBY CERTIFY, That I attended deceased from July 17th, 1920, to Aug 4th, 1920, that I last saw h e alive on August 4th, 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thomas L. Shearer, M. D.

Aug. 6, 1920 (Address) 905 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	8-7-1920.

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Balto St

N. B.—[illegible] mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45470 50 D45470

CERTIFICATE OF DEATH

(Write plainly with pen or pencil)

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 Maryland Ave ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Eber

(Residence in Baltimore: No. 413 Maryland Ave St.; ....yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Aug (Month) 5 (Day) 1920 (Year)

7-AGE, ...yrs. ....mos. 1 da. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, William Eber

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Elie Page

13-BIRTHPLACE OF MOTHER (State or Country), Bermuda

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Eber

(Address) 413 Marylandave West

15-

Filed ....., 191....

AUG 7 1920 G. H. Gross Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 6 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 5 1920, to Aug 6 1920, that I saw h alive on Aug 5 1920, and that death occurred, on the date stated above, at 9a. m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

.....

..... (Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary)

..... (Duration) ....yrs. ....mos. ....da.

(Signed) ..... M. D.

Aug 6, 1920. (Address) 1229 E Fairmount

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woslein	Aug 7, 1920
20-UNDERTAKER	ADDRESS
John J Fields	1200 W Fayette

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is especially important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45471 HEALTH DEPARTMENT—CITY OF BALTIMORE D45471

CERTIFICATE OF DEATH.

REGISTERED NO. 895

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1743 Hanover ST.: 23 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Deloris Smith

(a) RESIDENCE. NO. 1743 Hanover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 20 1917

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Smith.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elviah Stans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John Smith. (Address) 1743 Hanover St.

15 Filed AUG 7 1920 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1920 to Aug 5 1920

that I last saw h alive on Aug 5 1920

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. E. Campbell M. D.

Aug 6 1920 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	8/7/ 19
20 UNDERTAKER	ADDRESS
Wm J. & Edw. Ireland Inc	1427 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S NAME AND ADDRESS should be stated EXACTLY. PHYSICIAN'S NAME AND ADDRESS should be carefully supplied. AGE

Stmt. 6-9-13—H. P. Co.—1000 Blks.

D45472 HEALTH DEPARTMENT—CITY OF BALTIMORE D45472

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 Patapsco ave ST.: 25 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Fairring

(a) RESIDENCE. No. 3rd + Patapsco Ave ST. Brooklyn WARD. 25.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY. WITH CARE AND ACCURACY. PHYSICIAN'S mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates. OCCUPA-

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	wh.	M.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Fairring

6 DATE OF BIRTH (month, day, and year) Sept 6 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	Sept 6.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jas Stansbury

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Harriet Connell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Robt McFairring
(Address) 412 Patapsco ave

15 Filed AUG 7 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 4 1920 to Aug 4 1920

that I last saw her alive on Aug 4 1920

and that death occurred, on the date stated above, at 8/5 20 m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) H. W. Johnson, M. D.

, 19 (Address) Brooklyn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	8/9 19
20 UNDERTAKER	ADDRESS
Wm J. E. Groves	1745 Dillon

Spec.—6-9-19—H. P. Co.—1000 Blks.

845473 HEALTH DEPARTMENT—CITY OF BALTIMORE 845473

CERTIFICATE OF DEATH. 1045

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 James St ST.; 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Emalen Butler

(a) RESIDENCE. No. 1319 James St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 3, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		16		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Buckler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lizzie Gray.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Adam Buckler. (Address)

15 Filed AUG 7 1920 G. H. Cresse Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-8-20 19

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1920, to August 8, 1920, that I last saw him alive on August 5, 1920, and that death occurred, on the date stated above, at 2 30 a m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Duration

(duration) yrs. / mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Shepherd Dean. M. D.

. 19 (Address) 1127 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	8/7 19
20 UNDERTAKER Wm J. E. Gonzales	ADDRESS 1414 Edm Ave

N. B.—WRITE PLAINLY, WITH INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of DISEASE mation should be carefully supplied. AGE should be properly classified. Exact statement of DISEASE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45474 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45474

136

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. Genl. Hosp. (ST.:) 14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Myrtle Ogle

(a) RESIDENCE. No. 1737 Pennsylvania Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Daniel Webster Ogle

6 DATE OF BIRTH (month, day, and year) Aug. 11/1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Chas. Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Brest, Maryland

12 MAIDEN NAME OF MOTHER Annie Forker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland.

14 Informant (Address)

15 Filed AUG 7. 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5th 1920

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1920, to Aug. 5th, 1920, that I last saw her alive on Aug 5th, 1920, and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Pregnancy uncomplicating Caesarian Section

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Intestinal Obstruction (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug. 5/20

Was there an autopsy? No

What test confirmed diagnosis? Laparotomy

(Signed) Fred C. Smith, M. D.

, 19 (Address) Md. Genl. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 9 1920
20 UNDERTAKER	ADDRESS
Frank Sy for Hoon or Mart	

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be stated EXACTLY

Spec.—6-9-19—H. P. Co.—3000 Bks.

D45475 HEALTH DEPARTMENT—CITY OF BALTIMORE D45475

CERTIFICATE OF DEATH. 15 V

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 856 W. Pratt St ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Palacorolla

(a) RESIDENCE. No. 856 W Pratt ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 29 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Vin. Palacorolla

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Jennie Palacorolla

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant Vincent Palacorolla (Address) 856 W. Pratt St.

15 Filed . 19 G. H. Cross Registrar

AUG 7 1920.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1920

17 I HEREBY CERTIFY, That I attended deceased from August 5, 1920, to Aug 6, 1920, that I last saw h— alive on Aug 6, 1920, and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:

Congenital Weakness

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Kenney M. D.

19 24 (Address) 1815 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents Cem	Aug 7 1920
20 UNDERTAKER	ADDRESS
John J Kaley & Sons	318 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

SIMMS

D45476

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45476

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 Druid Hill Ave WARD) 17

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marion D. Simms

(Residence in Baltimore: No. Life time - St.) 36 yrs. 3 mos. 4 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April 30, 1884
(Month) (Day) (Year)

7-AGE, 36 yrs. 3 mos. 4 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Richard Simms

11-BIRTHPLACE OF FATHER (State or Country). Baltimore, Md

12-MAIDEN NAME OF MOTHER Mary Douglas

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William F. Simms

(Address) 1212 Druid Hill Ave

15- Filed Aug 7 1920, 19.. C. H. Cross Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 4, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 20 1920, to Aug 4 1920, that I saw her alive on Aug 3 1920, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

Hæmorrhage. Gave about 4 months da.
(Duration) yrs. mos.

CONTRIBUTORY Tuberculosis of Lungs
(Secondary)

Hæmorrhage. Gave about 4 months da.
(Duration) yrs. mos.

(Signed) Frances A. Carpenter M. D.

Aug 4..., 1920 (Address) 210 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, [redacted] Cemetery — DATE OF BURIAL, Aug. 7.., 1920

20-UNDERTAKER Clement Hall — ADDRESS 1945 Penna ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45477 HEALTH DEPARTMENT—CITY OF BALTIMORE D45477

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1014 Briscoe ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Bayline

(a) RESIDENCE. NO. 1014 Briscoe ST., WARD. 21

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 13 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass Blower

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Mr. Swindell

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Bernard Bayline

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Lechner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant John J. Bayline (Brother)
(Address) 524 N. Chester St

AUG 7 1920

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1920

17 I HEREBY CERTIFY, That I attended deceased from July 22 1920, to Aug 5 1920, that I last saw him alive on Aug 4 1920, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. 2 mos. 1st ds.

CONTRIBUTORY (Secondary) Tabular Gout

Uraemia (duration) — yrs. one mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physician

(Signed) W. H. Hamm, M. D.

. 19 (Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug. 9 1920.
20 UNDERTAKER	**ADDRESS**
James Dignan & Son	1000 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE BLANKS must be filled EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 45478

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45478

CERTIFICATE OF DEATH.

REGISTERED No. C 9178

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S.P.H.S.Hospital #56 ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Wrotniewski

(Residence in Baltimore: No. U.S.P.H.S.Hospt. #56, Fort McHenry St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... Unknown ....., 1899
(Month) (Day) (Year)

7-AGE, 21 yrs. -- mos. -- ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Seaman .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw. J. Beardsley Reg. Nurse

(Address) Fort McHenry Md

15- AUG 7 1920, 191 ..... G. H. Giese.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... August 6, 1920 ....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 30 1920, to August 6 1920, that I saw h-- alive on Aug 6 1920, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

...Endocarditis, acute and Broncho-...
...pneumonia.....

..... (Duration) ....yrs. ....mos. 7 ...ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

Aug 6 1920 (Address) Fort McHenry Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death -- yrs. -- mos. 7 ds. In the State Md. yrs. --- mos. 7 ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Unknown

19-PLACE OF BURIAL OR REMOVAL, Camden N J. DATE OF BURIAL, Aug 7, 1920

20-UNDERTAKER D. Lisson & Bro ADDRESS 110 E Balto St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 45479

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45479

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 W. Fayette ST. 18 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles W. Newton

(Residence in Baltimore: No. 1202 W. Fayette St.; 44 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 19 (Day), 1834 (Year)

7-AGE, 86 yrs. 7 mos. 18 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired 30
(b) General nature of industry, business, or establishment in which employed (or employer): Construction Engineer

9-BIRTHPLACE, (State or Country), Washington Mass

PARENTS.

10-NAME OF FATHER, Pierpont E. Newton

11-BIRTHPLACE OF FATHER (State or Country), Conn

12-MAIDEN NAME OF MOTHER Tamson Meecham

13-BIRTHPLACE OF MOTHER (State or Country), Conn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen M. Newton

(Address) 1202 W. Fayette St

15- Filed AUG 7 1920 191..... O. L. Grese, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 6 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 31 1920, to Aug 6 1920, that I saw him alive on Aug 5 1920, and that death occurred, on the date stated above, at 1.40 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(Duration) 1 yrs. 7 mos. 6 ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis

(Duration) About 5 yrs. 7 mos. 7 ds.

(Signed) Henry C. Parke M. D.

Aug 6, 1920. (Address) 1203 W. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Lorraine Cemetery	Aug 9, 1920
20-UNDERTAKER John A. Mitchell	ADDRESS 1201 W. Fayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D45480 HEALTH DEPARTMENT—CITY OF BALTIMORE D45480

WRITE PLAINLY, WITH INK. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

REGISTERED No. C 37

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1404 Woodall st. St.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward E.Beimschla.

(Residence in Baltimore: No. 1404 Woodall St. St.: 53 yrs., 10 mos. 15 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, September 22nd. 1866, 1
(Month) (Day) (Year)

7-AGE, 53 yrs. 10 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ship carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Henry Beimschla.

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER Catherine Wagner.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nettie B.Beimschla. (wife)

(Address) 1404 Woodall St.

15- FILED AUG 7 1920, 191 G. H. Crose Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 6th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture of an Aortic Aneurism.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Aug 6, 1920 (Address) 1017 S.Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
London Park Cem	Aug 9th 1920
20-UNDERTAKER	ADDRESS
E Schloman & Son	1039 Hanover St

Spec. 6-9-19—H. P. Co.—1000 Bks.

D45481 HEALTH DEPARTMENT—CITY OF BALTIMORE D45481

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 Jackson, ST.: 24 WARD) 104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna L. Fincher.

(a) RESIDENCE. No. 1635 Jackson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 26. 1918.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none. (Child)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Philip J. Fincher.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Edna George

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Philip J. Fincher
(Address) 1635 E. Jackson

15 Filed AUG 7 1920 A. M. Cook Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1920

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1920, to Aug 6, 1920, that I last saw h[illegible] alive on Aug 5- 1920, and that death occurred, on the date stated above, at 3.- A. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. T. Slabury, M. D.

Aug 7, 1920 (Address) 638 Fark ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Aug 7 1920
20 UNDERTAKER	ADDRESS
E Schloman & Son	1034 Monroe St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. Exact statement of AGE should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45482

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45482

CERTIFICATE OF DEATH.

43

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 W 21st St. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jones

(a) RESIDENCE. No. 123 W 21st St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of married

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
70				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary E Boadley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hattie Barkins. (Address) 123 W 21 St Baltimore

15 FILED AUG 7 . 1920 C. H. Crese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1920

17 I HEREBY CERTIFY, That I attended deceased from June 28. 1920. to Aug 5. 1920.

that I last saw h.. alive on Aug 4. 1920.

and that death occurred, on the date stated above, at 5.45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of left Mammary Gland

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Geo Hall, M. D.

. 19 (Address) 426 E 23 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Aug 7 1920
20 UNDERTAKER Mrs R A Elliott	ADDRESS 725 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. mation should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45483 D45483

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 E. Gittings ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary I. Wolf

(a) RESIDENCE. NO. 413 E. Gittings ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 6 ds. How long in U. S., if of foreign birth? yrs. 8 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 30-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frederick L. Wolf.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Eva. Smyton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant F. L. Wolf. (Address) 413 E. Gittings

15 Filed AUG 7 1920 . 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 5 . 1920 . to Aug 6 . 1920 . that I last saw h w alive on Aug. 6 . 1920 . and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

abt (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Robt. B. G. Schmidt . M. D.

8/7 . 1920 (Address) 1818 St. Clair pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Western Cem	8/9 1920
20 UNDERTAKER J. Frew McCully	ADDRESS 130 E. Fay

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. PHYSICIAN'S OFFICE ADDRESS and OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement may be made in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45484 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45484

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 833 S. Third ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer Leroy Knachel, Jr.

(a) RESIDENCE. NO. 833 S. Third ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 30-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Elmer L. Knachel. Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary E. Lemke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mary E. Knachel
(Address) 833 S. Third St.

15 Filed AUG 7 1920 C. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1920

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1920, to Aug 6, 1920, that I last saw him alive on Aug 6, 1920, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Mes. Calculus

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Hamar B Tillow M. D.

8/6, 1920 (Address) 2921 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cem.	Aug 8 1920
20 UNDERTAKER Zickler & Zickler	ADDRESS 1739 E. Eager

N. B.—WRITE PLAINLY, with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D45485 HEALTH DEPARTMENT—CITY OF BALTIMORE D45485

CERTIFICATE OF DEATH. 172

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1st Ave & 4th St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Conrad Pfarr

(Residence in Baltimore: No. 1017 Eutaw Ave St.; yrs., 19 mos. dys.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are required by law to fill out this CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH INK.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept. (Month) 14 (Day), 1900 (Year)

7-AGE, 19 yrs. 10 mos. 21 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Rivet Heater
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Anthony Pfarr.

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER, Margaret Chaser

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anthony Pfarr

(Address) 1017 Eutaw St

15-

Filed AUG 7 1920, 19.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 5 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Shot from Shell

Causing Fracture of Skull

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) Edward Fyffe Weber M. D.

(Coroner)

Aug 7 1920 (Address) 1604 Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Aug. 9, 1920

20-UNDERTAKER Gibler & Gibler — ADDRESS 1739 E. Eager

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 45486

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45486

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1334 Presstman ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elijah Hankins

(a) RESIDENCE. No. 1334 Presstman ST., ... WARD. Lifetime

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~) of Rebecca Hankins

6 DATE OF BIRTH (month, day, and year) July 4 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sexton of

(b) General nature of industry, business, or establishment in which employed (or employer) St. Bartholomew's Church

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Richard Hankins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Ellsworth Hankins

(Address) 1334 Presstman St

15 Filed AUG 7 1920 C. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 4 1920 to Aug 5 1920, that I last saw him alive on Aug 5 1920, and that death occurred, on the date stated above, at 8.45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E William Frey, M. D.

8/5, 1920 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Aug 8 1920
20 UNDERTAKER	ADDRESS
Edw. Ringgold	1463 Carey St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS' and UNDERTAKERS' reports should be stated EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D45487 HEALTH DEPARTMENT—CITY OF BALTIMORE D45487

1042

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1812 Mullin ST. 7 WARD)
2-FULL NAME Not Named - (Cooper)
(Residence in Baltimore: No. 1812 Mullin St.)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M-	C	Single

6-DATE OF BIRTH, 7/ (Month) 29/ (Day), 1920 (Year)

7-AGE, ...yrs. .....mos. 7 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work — —
(b) General nature of industry, business, or establishment in which employed (or employer) — —

9-BIRTHPLACE, (State or Country) Balto. Md.

PARENTS.
10-NAME OF FATHER, Isaac Cooper.
11-BIRTHPLACE OF FATHER (State or Country) Baltimore. Md
12-MAIDEN NAME OF MOTHER, Lula Jones.
13-BIRTHPLACE OF MOTHER (State or Country) Howard Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lula Jones
(Address) 1812 Mullins St

15-
Filed AUG 7 1920 C. H. Gross
Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8- 5 (Month) (Day), 1920 (Year) 5:30 pm

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Intestinal Rickets
(Duration) ....yrs. .... mos. 6 ds.
CONTRIBUTORY (Secondary) Inanition
(Duration) ....yrs. .... mos. 1 ds.

(Signed) C. C. Blades M. D.
(Coroner)
8/5/20 (Address) 1436 Bray

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dr Peters
DATE OF BURIAL, Aug 8, 1920
20-UNDERTAKER Edward Runge
ADDRESS 1463 N Carey St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45488

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45488

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Vincent Asylum St.; 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Graham

(a) RESIDENCE. No. St Vincent Asylum ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Boy	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: single

6 DATE OF BIRTH (month, day, and year): apr. 13th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of Industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore city

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Thresa Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richmond Va.

14 Informant: St Vincents Dept Asy

(Address) 1401 Division St.

15 Filed AUG 7 1920 C. E. Cress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 6 1920

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1920, to Aug 6, 1920, that I last saw h[illegible] alive on Aug 5, 1920, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Illeo Colitis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas Heath M. D.

Aug 7 1920 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Aug. 7 1920
20 UNDERTAKER	ADDRESS
Marlow Undertaking Co	1827 N Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 45489

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45489

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1600 Druid Hill Av. ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Hinton

(Residence in Baltimore: No. 1600 Druid Hill Av. St.; 16 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, — (Month) — (Day) 1877 (Year)

7-AGE, 43 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... Genl Hse

9-BIRTHPLACE, (State or Country). Shepherdstown W Va

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Mollie Washington

13-BIRTHPLACE OF MOTHER (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert A. Hinton

(Address) 1600 Druid Hill Av

15- G. H. Grese

Filed AUG 7 1920 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 5 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1920, to Aug 5th 1920, that I saw her alive on Aug 3 1920, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

.....

.....Chronic Interstitial.....

.....Nephritis..... (Duration) — yrs. 3 mos. — ds.

CONTRIBUTORY Cardiac Edema

(Secondary)

..... (Duration) — yrs. 2 mos. — ds.

(Signed) Edward E. Mackenzie M. D.

Aug 6th, 191.. (Address) 1301 North Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Farmer or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Aug 7, 1920

20-UNDERTAKER JAMES H. DENNIS — ADDRESS 1303 PRESTMAN ST.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45490 ✓ D45490

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

143

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 E. Biddle ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh McLaughlin

(a) RESIDENCE. NO. 217 E. Biddle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. McLaughlin

6 DATE OF BIRTH (month, day and year) Dec 25 - 1854

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) Broker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Hugh McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary E. McLaughlin (Address) 217 E. Biddle St

15 Filed AUG 7 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 3 . 1920 . to Aug 5 . 1920 that I last saw him alive on Aug 5 . 1920 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Septicinfection

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Carbuncle

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr Bernardsen, M. D.

8/6 1920 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Aug. 9th 1920

20 UNDERTAKER Chas F. Evans & Son ADDRESS 118 W. Mt. Royal ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION mation should be properly classified. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D45491 HEALTH DEPARTMENT—CITY OF BALTIMORE D45491

CERTIFICATE OF DEATH.

150

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1431 E.Clement St. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Gurry Jr.

(Residence in Baltimore: No. 1431 E.Clement St. St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single.

6-DATE OF BIRTH, August 6th. 1920., 1 (Month) (Day) (Year)

7-AGE, ...yrs. ....mos. ....ds.

If LESS than 1 day, 5 hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER: John Gurry Sr.

11-BIRTHPLACE OF FATHER (State or Country): Baltimore, Md.

12-MAIDEN NAME OF MOTHER: Agnes Carroll.

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes Gurry. (mother)

(Address) 1431 E.Clement St.

15- Filed AUG 7 1920 191... W H. Gra... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 6th, 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
congenital.
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....
(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

Aug. 6., 1920. (Address) 1017 S.Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross C. Asso. DATE OF BURIAL, Aug 7, 1920

20-UNDERTAKER John J Tarleton ADDRESS 138 Light St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

845492

CERTIFICATE OF DEATH.

1948 45492

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1139 (St.) Wiconico (Ward) 21

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Ottmann

(a) RESIDENCE. No. 1139 St., Wiconico Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 5 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 6-62

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Glass House

(c) Name of employer Swindells Baltimore Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Peter Ottmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Brockhoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Nazarenus (Address) 1234 Scott St.

15 Filed AUG 7 1920 G. H. G... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 4 1920 to Aug 6 1920, that I last saw him alive on Aug 4 1920, and that death occurred, on the date stated above, at 8.30 A.m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) no yrs. no mos. 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Reynolds Glaser, M. D.

19 (Address) Parkland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Aug 9th 1920

20 UNDERTAKER Mr. & Mrs. John H. Deufel. ADDRESS 801 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

6-9-19—H. P. Co.—1000 Blks.

D45493

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D45493

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 4th East Brookly ST.; 35 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Herbert

(a) RESIDENCE. No..... ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 6, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) East Brooklyn Md

PARENTS

10 NAME OF FATHER John Herbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Philadelphia

12 MAIDEN NAME OF MOTHER Minnie Steinbrecher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) East Brooklyn

14 Informant Herbert Herbert

(Address) 1713 2d ave Wagners Point

15 AUG 7 1920 C. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 6 1920 to Aug 7 1920

that I last saw him alive on Aug 6 1920

and that death occurred, on the date stated above, at 1.30 a. m.

THE CAUSE OF DEATH* was as follows:

Premature Birth

(7 months)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lizz D. Storka, M. D.

(Address) Curtis Bay Md Aug 7 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery a.a. Co. Md	aug 7 1920

20 UNDERTAKER ADDRESS

Margaret G. Flynn 1422 Light st.

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS' NAMES MUST BE STATED EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

D45494 HEALTH DEPARTMENT—CITY OF BALTIMORE D45494

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 109 E Woodland Ave WARD) 27

REGISTERED No. C 19

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Campbell

(Residence in Baltimore: No. 109 E Woodland Ave St. 65 yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.): Widow

6-DATE OF BIRTH: March 17, 1849 (Month) (Day) (Year)

7-AGE: 71 yrs. 4 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: John McIntyre

11-BIRTHPLACE OF FATHER (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Mary Russell

13-BIRTHPLACE OF MOTHER (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Eckelam

(Address) 109 E Woodland Ave

15-

Filed AUG 7 1920 G. H. Cr...

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Aug. (Month) 6 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by said Inq (Inquest or Inquiry) and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Morrises M. D. (Coroner.)

Aug 7 1920 (Address) 5632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: H. Peters Lot — DATE OF BURIAL: Aug 9. 1920

20-UNDERTAKER: Wm Cook — ADDRESS: 502 E North

Coroner Morrises 3632 Roland Ave.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45495 ✓ D 45495

D45495

CERTIFICATE OF DEATH.

8 170

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1703 N. Rayster ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lester Jane Maynard

(Residence in Baltimore: No. 1703 N. Rayster St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, November 1, 1849
(Month) (Day) (Year)

7-AGE, 70 yrs. 9 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Jacob Farver

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Martha E. Jones

13-BIRTHPLACE OF MOTHER (State or Country), Richmond Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daughter

(Address) 1703 Rayster

15- G. H. Grier

Filed AUG 7 1912, 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 5, 1912.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 2nd 1912, to Aug 5 1912, that I saw h.. alive on Aug 5 1912, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Apoplexy Cerebral

(Duration) yrs. mos. 2 ds.

(Signed) John T Owens M. D.

Aug 7, 1912 (Address) 1603 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Johns Waverly — DATE OF BURIAL, Aug 9, 1912

20-UNDERTAKER Wm. Cook — ADDRESS 502 E Monument Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45496 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45496

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mercy Hosp. St.: 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Kelly

(a) RESIDENCE. No. 816 N. Mount St. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bottle - washer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Peter Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mary Gilbert 1641 W. Lafayette Ave

15 Filed AUG 7 1920 C. H. Grimm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/6 1920

17 I HEREBY CERTIFY, That I attended deceased from 7/15 1920, to 8/6 1920, that I last saw h alive on 8/6 1920, and that death occurred, on the date stated above, at 2:01 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry L. Rudasky M. D

8/6 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Belair Harford Co. Md	Aug 8 1920
20 UNDERTAKER	ADDRESS
Wm. Cook	502 E Hoffman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Baltimore, Md. August 12, 1920.

I do hereby make oath that the name given on Baltimore City Health Department Death Certificate No. D-45496 as Mrs. Mary Kelly is not correct and same should be Mrs. Mary C. Culley; also that the age given on said certificate is incorrect, same should be 72 years instead of 59 years and 24 days.

Irvin D. Ridgely.
Physician.

Subscribed and sworn to before me this 12th day of August, 1920.

Reed Gaither
Notary Public.

D45497 HEALTH DEPARTMENT—CITY OF BALTIMORE D45497

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1045 Brantley Ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Peacock.

(Residence in Baltimore: No. 1045 Brantley Ave St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M-

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Married

6-DATE OF BIRTH, 12 / 3 / 1827- (Month) (Day) (Year)

7-AGE 93- yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or Country) Md. Maryland

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Rebecca Dorn

13-BIRTHPLACE OF MOTHER (State or Country) Not known.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Duncan

(Address) 1045 Brantley Ave

15-

Filed AUG 7 1920 G. H. Gross

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 / 6 / 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Senility

Aortic Sclerosis

(Duration) mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

Signed G. C. Glade M. D. (Coroner)

8/6/20 (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, London Park Cem. DATE OF BURIAL, Aug 9, 1920

20-UNDERTAKER Wilbur W. Shriver ADDRESS 1088 Edmondson Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

45498

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45498

CERTIFICATE OF DEATH.

X 40

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1006 Arlington Ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Milligan

(a) RESIDENCE. No. 1006 Arlington Av ST., WARD

(Usual place of abode) (If not in Baltimore give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Female Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Milligan

6 DATE OF BIRTH (month, day, and year): Jan 21 1860

7 AGE — Years: 56 — Months: 4 — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Butler co Md

PARENTS

10 NAME OF FATHER: Richard Fry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Butler co Md

12 MAIDEN NAME OF MOTHER: Mrs. Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll co Md

14 Informant: Agnes Fry (Address): Reisterstown Md

15 Filed AUG 7 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1920, to Aug. 6, 1920

that I last saw her alive on Aug. 6, 1920

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Edward J. Wheatley, M. D.

8/7, 1920 (Address) 1936 Division Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pinney Grove Cemetery	Aug 7 1920
20 UNDERTAKER	ADDRESS
G. F. Elliott	Reisterstown Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION IS REQUIRED EXACTLY. PHYSICIAN'S name and address should be stated EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact information may be properly classified. Exact information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S name and address should be stated EXACTLY. OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it

Spec.—8-24-14—M. & T.—2000 Blks.

D.45499 D.45499 150 D.45499

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Florence Cullenton Mus St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Fawn (foundling)

(Residence in Baltimore: No. ..... St.; ..... yrs., 3 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, W

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.) Single

6-DATE OF BIRTH, Not Known (Month) (Day) (Year)

7-AGE, about 3 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Not Known

PARENTS.

10-NAME OF FATHER, "

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John C. Baldwin

(Address) 501 Roz Bldg

15-

Filed AUG 7 1920, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 5 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1920, to Aug 5 1920, that I saw her alive on Aug 5 1920, and that death occurred, on the date stated above, at 3.30 P.m.

The CAUSE OF DEATH* was as follows: Status thymico lymphaticus

Since Birth

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Administration of Prophylactic dose of Diphtheria Antitoxin

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John C. Baldwin M. D.

Aug 6, 1920 (Address) 501 Roz Bldg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 2 mos. 5 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Anatomical Board DATE OF BURIAL, ..., 191...

20-UNDERTAKER ..... ADDRESS .....

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If [illegible] of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement may

Spec.—8-24-14—M. & T.—2000 Bks.

D. 45500

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45500

CERTIFICATE OF DEATH.

151

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 943 N. Chester ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Inf of John + Emma Laughert

(Residence in Baltimore: No. 943 N. Chester St St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH: Aug 6- 20, 1 (Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or 5 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: John Laughert

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Emma M. Huse

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J. Laughert

(Address) 943 N. Chester st

15- Filed AUG 7 1920, 191.... Robert P. Harrison, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 6, 1912 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 6 1912 to Aug 6 1912, that I saw h[illegible] alive on Aug 6 1912, and that death occurred, on the date stated above, at 10 05 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Ruptured Bile

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John B Lemmon M. D.

Aug 6, 1912 (Address) 718 N Patterson Pk

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, John Hopkins — DATE OF BURIAL, ..., 191...

20-UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in every case. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 45501

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45501

CERTIFICATE OF DEATH.

64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2306 Druid Hill Ave St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Fannie Irene Birkett

(Residence in Baltimore: No. 2306 Druid Hill Ave St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH: Feby 17, 1863 (Month) (Day) (Year)

7-AGE: 57 yrs. 5 mos. 24 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dress Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 269

9-BIRTHPLACE, (State or Country): Baltimore Co. Md

PARENTS.

10-NAME OF FATHER: Homer Birkett

11-BIRTHPLACE OF FATHER (State or Country): England

12-MAIDEN NAME OF MOTHER: Mary Shenick

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Maxine Green

(Address): 2306 Druid Hill Ave

15- Filed AUG 8 1920, 191.... Robert P. Harrison, Registrar.
Burial Permit Cl...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: August 6th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 6 1920, to Aug 6 1920, that I saw h.r alive on Aug 6 1920, and that death occurred, on the date stated above, at 7:20 m.

The CAUSE OF DEATH* was as follows:

Paralysis (Cerebral Hemorrhage)

24 hours
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Acute Bright's Disease

Unknown
(Duration) ... yrs. ... mos. ... ds.

(Signed) O. A. Duvall M. D.

Aug 6, 191... (Address) 1807 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Olivet Cem Randallstown DATE OF BURIAL, Aug 9, 191...

20-UNDERTAKER: Harry A. Eblen ADDRESS 1920 N. Gilmor

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.45502

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45502

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Le Jeune Hospital ST. 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Madam

(Residence in Baltimore. No. 756 W Hyalberry St. 47 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1870
(Month) (Day) (Year)

7-AGE, 50 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.... Cook
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Delaware

PARENTS.

10-NAME OF FATHER Dont know

11-BIRTHPLACE OF FATHER (State or Country) Dont know

12-MAIDEN NAME OF MOTHER Dont know

13-BIRTHPLACE OF MOTHER (State or Country) Dont know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Penna ave

15-

Filed AUG 8 1920, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 6, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Autopsy
(Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Syphilis.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) ... yrs. ... mos. ... ds.

(Signed) Robt Priestley M. D.
(Coroner.)

8-6, 1920 (Address) 4 E Eden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Seaford Delaware

DATE OF BURIAL, Aug 9 1920

20-UNDERTAKER Daniel Easton

ADDRESS 916 Penna ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.455503

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.455503

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4188 Duncan (St.) 1 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benedict Krawczyk

(a) RESIDENCE. No. 418 S Duncan St., Ward.
(Usual place of abode) (If nonresid. give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	7.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Feliks Krawczyk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Jocesta Damatky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Feliks Krawczyk
(Address) 418 S Duncan St.

15 Filed AUG 8 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 2 . 1920 . to Aug 7 . 1920
that I last saw him alive on Aug 7 . 1920.
and that death occurred, on the date stated above, at 1.30 P m.
The CAUSE OF DEATH* was as follows:

Cardiac Colelis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leo S Dreyack, M. D.

. 19 (Address) 2818 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	August 9 1920

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
mation should be carefully supplied. AGE should be stated EXACTLY
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.
PHYSICIANS should state Exact date of OCCUPA-

D.45504

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45504

CERTIFICATE OF DEATH.

175-004

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Lo Dept Hospital St. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Gordon

(Residence in Baltimore: No. 236 S Spring St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6-DATE OF BIRTH: July — , 1913 (Month) (Day) (Year)

7-AGE: 8 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Aaron Gordon

11-BIRTHPLACE OF FATHER (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Fannie Arad

13-BIRTHPLACE OF MOTHER (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Balto St

15-

Filed AUG 8 1920, 191.... Registrar.

Robert P. Harrison, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 6 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

Heart Cond

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

8-6-, 1920 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 7 ds. In the State Life yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 236 S Spring St

19-PLACE OF BURIAL OR REMOVAL: Kehsen Rosedale — DATE OF BURIAL: 8/8, 1920

20-UNDERTAKER: Jack Lewis — ADDRESS: 1411 E Balto

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS OF

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 45505 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 45505

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1147 E. LOMBERD ST. ST.: 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Pershitz

(a) RESIDENCE. NO. 1147 E Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Sam Lewis
(Address) 1411 E Baltimore

15 Filed AUG 8 1920 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-7 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb 21 . 1920 . to Aug 6 . 1920 . that I last saw h[illegible] alive on Aug 6 . 1920 . and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the mediastinum

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed) M Oberndorf, M. D

. 19 (Address) 2328 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehren Woodlawn	8/8 1920
20 UNDERTAKER Jack Lewis	ADDRESS 1411 E Balt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. Place of CAUSE OF DEATH should be properly classified. Exact statement of OCCUPATION may be in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45506 ✓ D.45506

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 N. Gilmor ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Atkinson Barnett

(a) RESIDENCE. NO. 705 N. Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Elizabeth S. Barnett

6 DATE OF BIRTH (month, day, and year) Sept. 26. 187[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manager

(b) General nature of industry, business, or establishment in which employed (or employer): Pork Packers

(c) Name of employer: J. C. Shafer & Co

9 BIRTHPLACE (city or town) (State or country): Allegheny Co Penna

PARENTS

10 NAME OF FATHER: Wm Barnett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary E. Atkinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Miss Irene Barnett
(Address): 705 N. Gilmor St

15 Filed AUG 8 1920, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6. 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1919, to Aug 6, 1920.

that I last saw h~~im~~ alive on Aug. 6, 1920.

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Melanotic Sarcoma of leg

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Sarcoma of Brain

(duration) ... yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 1/20

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Henry Straus, M. D.

8/7. 1920 (Address) 23 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: London Park — DATE OF BURIAL: Aug 9 1920

20 UNDERTAKER: Geo W Little — ADDRESS: 531 N Fremont Ave

Robert F. Harrison
Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN should state mation should be carefully supplied. AGE should be stated EXACTLY if possible. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20,455 07

HEALTH DEPARTMENT—CITY OF BALTIMORE

20,455 07

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Josephs Hospital (WARD) 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Dirla

(a) RESIDENCE. NO. 1810 N. Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 5, 1909. 19 y

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Glaby

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER Thomas Dirla

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER Barbara Grana

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant Thomas Dirla
(Address) 1810 N Chester

15 Filed AUG 8 1920 19 ... Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6 19 20

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 19 20, to Aug 6, 19 20,
that I last saw him alive on Aug 6, 19 20,
and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows: Interocular Hemorrhage

(duration) ... yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary) Tuberculosis Pulmonary

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical findings

(Signed) F. A. Marino, M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Aug 9 1920

20 UNDERTAKER: Wendell Appel & Son — ADDRESS: 878 N

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45508 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45508

CERTIFICATE OF DEATH.

REGISTERED NO. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 S. Noris ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anton Forisiak

(a) RESIDENCE. NO. 403 S. Noris ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 20 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Stephen Forisiak

11 BIRTHPLACE OF FATHER (city or town) Worreva
(State or country) Poland

12 MAIDEN NAME OF MOTHER Mariana Wardaska

13 BIRTHPLACE OF MOTHER (city or town) Worreva
(State or country) Poland

14 Informant Stephen Forisiak
(Address) 403 S. Noris st

15 Filed AUG 8 1920, 19 Robert P. Harrigan,
Registrar
Frank Bennett Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-6-1920

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1920, to August 5, 1920, that I last saw h... alive on August 5, 1920, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Indigestion
(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? the condition

(Signed) H Smoldenski, M. D.

, 19 (Address) 722 S. Eaton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross S. S. Co.	Aug. 9 1920
20 UNDERTAKER Wm Fialkowski 1418 Eastern ave	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. If d be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.45509 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45509

CERTIFICATE OF DEATH. 114

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 13 WARD)

2-FULL NAME Mr. David Weil

(a) RESIDENCE. NO. 2320 David Hill Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S ... should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ... TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Julius Weil

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Jennie Sussmyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hop. Record

(Address)

15 Filed AUG 8 1920 Robert P. Garrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7 1920

17 I HEREBY CERTIFY, That I attended deceased from July 20. 1920. to Aug 7. 1920.

that I last saw him alive on Aug. 5 1920.

and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis + Cholelithiasis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 20

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Emma D. Richards, M. D.

2/7, 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	Aug 9 1920
20 UNDERTAKER	ADDRESS
J Ahrens & Co	1611 Mad ave

Spec.—8-24-14—M. & T.—2000 Bks.

D. 45510

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45510

105

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Poplar & Oak Sts ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Rebecca Warfield

(Residence in Baltimore: No. Oakley, Balto. St.; 76 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ~~Date~~ March (Month) 16th (Day), 1839 (Year)

7-AGE, 81 yrs. 5 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... At home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Maryland America

PARENTS.

10-NAME OF FATHER, Thomas B. Warfield

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Isabella Lucas

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Laura M. Burchell

(Address) Oakley Md.

15- Robert P. Harrison,

Filed AUG 8 1920, 191.....

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug. (Month) 7 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Aug 7th 1920, that I saw h[illegible] alive on Aug 6th 1920, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

.....

.....

Old Age

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Gastro-Enteritis

..... (Duration) ..... yrs. ..... mos. 7 ..... ds.

(Signed) Lucian A. Fritz M. D.

8/7, 1920. (Address) Oakley

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Olivet Cemetery	Aug. 10th, 1920.
20-UNDERTAKER Fredk Lassahn & Son	ADDRESS Fallston Md.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.45511

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.45511

CERTIFICATE OF DEATH.

108

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jno Schieler

(a) RESIDENCE. NO. 120 Madeira ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eva M. Schoeler

6 DATE OF BIRTH (month, day, and year): July 5 1889

7 AGE: Years 31 Months 1 Days 1 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pipe fitter Helper

(b) General nature of industry, business, or establishment in which employed (or employer): Penn R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Gustave Schoeler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Beidenbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Hospital Records (Address)

15 Filed AUG 8 1920 19.... Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 6 1920

17 I HEREBY CERTIFY, That I attended deceased from July 18 1920, to Aug 6 1920, that I last saw h— alive on Aug 6 1920, and that death occurred, on the date stated above, at 8 P. 30 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 3 wks. mos. ds.

CONTRIBUTORY (Secondary) Laparotomy Appendectomy Peritonitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hosp

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis

(Signed) J. M. Schwenck M. D.

19 (Address) St. Joseph's Hosp Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mathews bem

DATE OF BURIAL: Aug 9 1920

20 UNDERTAKER: Geo C. Miller

ADDRESS: 2334 Jeffers St

Spec.—8-24-14—M. & T.—2000 Bks.

D.45512

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45512

CERTIFICATE OF DEATH.

47

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 N castle st ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther v c winter

(Residence in Baltimore: No. 502 N castle st St.: 6 yrs. 6 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	child

6-DATE OF BIRTH, Jan 27, 1914 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
6 yrs. 6 mos. 12 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George E Hunter

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ada V Cochran

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ada Hunter

(Address) 502 N castle st

15-
AUG 8 1920, 191.....
Date. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 6, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 24 1920, to Aug 6 1920, that I saw h[illegible] alive on Aug 6 1920, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

End condition of Chronic acute rheumatic Heart trouble

(Duration) yrs. 12 mos. ds.

CONTRIBUTORY (Secondary) Acute Colitis 4 Days

(Duration) yrs. mos. ds.

(Signed) T. J. Kilpatrick M. D.

Aug 6, 1920 (Address) 500 N Castle St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem	Aug 9, 1920
20-UNDERTAKER	ADDRESS
Wm. C. Miller	2534 Jefferson St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PROFESSION should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45513

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45513

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 129 h Bradford St. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paulenia Demling

(Residence in Baltimore: No. 129 h Bradford st St.; 45 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) widow

6-DATE OF BIRTH. Dec 22 (Month) (Day), 1858 (Year)

7-AGE. 62 yrs. 10 mos. 17 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, H Pfankteler

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Otto Demling

(Address) 129 N. Bradford st

15-

Filed AUG 8 1920, 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 4 (Month) (Day), 1920 (Year).

I HEREBY CERTIFY, That I attended deceased from March 28 1920, to Aug 5 1920, that I saw her alive on Aug 3 1920, and that death occurred, on the date stated above, at 1.45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

about 1/2 (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Heller M. D.

8-6, 1920 (Address) 1937 Gough St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem

DATE OF BURIAL, Aug 9, 1920

20-UNDERTAKER Mrs E. Fuller

ADDRESS 2334 Jefferson

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 45514

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45514

CERTIFICATE OF DEATH.

51

REGISTERED NO.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. North Broadway ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Laura Mohlenrich

(a) RESIDENCE. NO. 519 N. Wolfe St. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. ? 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Henry Mohlenrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Amalia Werner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Henry Mohlenrich 519 N Wolfe St

15 Filed AUG 8 1920 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1920, to Aug 6, 1920, that I last saw her alive on Aug 6, 1920, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Exophthalmic goitre

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Aug 5, 1920

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. H. Noble M. D.

19 (Address) Church Home Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Aug 9 1920
20 UNDERTAKER	ADDRESS
John Heuwig do	2008 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY in all cases. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.45515 HEALTH DEPARTMENT—CITY OF BALTIMORE D.43515

169 ✓

CERTIFICATE OF DEATH.

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Off Fort McHenry. St.: 17 WARD)

2-FULL NAME William Conway (C)

(Residence in Baltimore: No. 1225 Pennsylvania Ave. St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH. April 4th. 1890, 1 (Month) (Day) (Year)

7-AGE. 30 yrs. 4 mos. ----- ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Lancaster, Va.

PARENTS.

10-NAME OF FATHER, William Ransom.(C)

11-BIRTHPLACE OF FATHER (State or Country). Virginia.

12-MAIDEN NAME OF MOTHER Letta Conway.(C)

13-BIRTHPLACE OF MOTHER (State or Country). Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mathhew Conway.(C)brother.

(Address) 578 Fresstman St.

15- Robert P[illegible] Harrison, Registrar.

Bod ....., 1920 ....., 191.. Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. August 4th. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally drowned by falling fro a scow.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto K. Reinhardt (Coroner)

Aug. 5, 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn. DATE OF BURIAL. Aug 9. 1920

20-UNDERTAKER Edward Ring Gold ADDRESS 1403 Y

45516

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 472

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2241 Barclay ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Jenkins

(Residence in Baltimore: No. 2241 Barclay St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, ? (Month) ? (Day) 1841 (Year)

7-AGE. 79 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Co. Md.

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alfred Mayers

(Address) 2271 E. 23rd Street

15- Filed AUG 8 1920, 191. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 7 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2 1920, to Aug 7 1920, that I saw h[illegible] alive on Aug 7 1920, and that death occurred, on the date stated above, at 8.50 A.M.

The CAUSE OF DEATH* was as follows: Chronic Articular Rheumatism

Duration 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) Senility 4 yrs. mos. ds.

(Signed) W. A. Coleman M. D.

Aug 7, 1920 (Address) 2037 McCulloh St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state: (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Quaker Bottom Co. DATE OF BURIAL, Aug. 9

20-UNDERTAKER W. C. Brooke ADDRESS Sparks, Md.

Missing

#D 45517

45518

CERTIFICATE OF [illegible] REGISTERED No.

1-PLACE OF DEATH Little Sisters of the Poor ST.; 7 WARD)

CITY OF BALTIMORE: (No. 45518

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice White St.; 30 yrs., mos., ds.)

(Residence in Baltimore: No. 1630 Mc Elderry

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Wid

6-DATE OF BIRTH, ... (Month) ..... (Day) 1837 (Year)

7-AGE, 83 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Cleveland Ohio

PARENTS.

10-NAME OF FATHER, Thomas Kane

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Bridgd Kane

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed ....., 191.... Harry S. [illegible] Registrar.

Aug 9 1920 Robert P. [illegible]

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 6, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from [illegible] 191.... to 191.... that I saw her alive on Aug 1 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Gangrene of foot

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. A. Warner M. D.

....., 191..? (Address) 1133 Valley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death yrs. 1 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1630 Mc Elderry St

19-PLACE OF BURIAL OR REMOVAL. Leuden Park DATE OF BURIAL. Aug 9 1920

20-UNDERTAKER Henry Lutz ADDRESS 1007 N. Bond St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45519 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45519

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST.: 23 WARD)

REGISTERED NO. 105

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Young

(a) RESIDENCE. NO. 919 Bevan Ste ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 6, 1914.

7 AGE: Years 6 Months 7 Days

If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

) Trade, profession or rticular kind of work: Child

, General nature of industry, siness, or establishment in hich employed (or employer)

c) Name of employer

BIRTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER: Howard Young

1 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

AIDEN NAME OF MOTHER: Hattie Gold

RTHPLACE OF MOTHER (city or town) tate or country): Maryland.

...ormant (Address): Hospital Record J. H. H.

15 Filed AUG 8 1920 Robert P. Harrison, Registrar

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1920, to Aug 6, 1920, that I last saw him alive on Aug 6, 1920, and that death occurred, on the date stated above, at 10: P m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Vomiting & diarrhoea

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? not in Hospital

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Un Hoff, M. D.

, 19 (Address) Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	Aug 9 1920
20 UNDERTAKER	ADDRESS 1037
E Schleman & Son	Saratoga St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45520 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45520

CERTIFICATE OF DEATH. 164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 317 S Wolfe St. 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wieslaw Wolgast.

(a) RESIDENCE. NO. 317 S Wolfe St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 14/19-

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas Wolgast

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Lojewska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant W. F. Sadowski.

(Address) 705 S. Ann St

15 Filed AUG 8 1920 19

Robert P. Harrison,

Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ANY mation should be carefully supplied. AGE sh CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) 8/7/20

17 I HEREBY CERTIFY, That I attended deceased from 8/7/20 19 to 8/7/20 19 that I last saw him alive on 8/7/20 19 and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Forgotten

(Signed) Chas. C. Fladus M. D.

(Address) 1456 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary.	Aug 9th 1920
20 UNDERTAKER W. F. Sadowski.	ADDRESS 705 S. Ann

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45521

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45521

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital St.: 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl B. Bradley

(a) RESIDENCE. No. 1216 Cleveland St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Marie Bradley

6 DATE OF BIRTH (month, day, and year) Dec 7 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship-yard Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jesse Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Julia Carrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Marie Bradley (Address) 1216 Cleveland St.

15 Filed AUG 8 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 7, 1920 to Aug. 8, 1920 that I last saw him alive on Aug. 8, 1920 and that death occurred, on the date stated above, at 6:30 A.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

OVW

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema

(duration) ..... yrs. ..... moc. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Urine Data

What test confirmed diagnosis?

(Signed) H. Hurst M.D.

8/8. 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Aug 11 1920

20 UNDERTAKER William Cook

ADDRESS 508 E Valley St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE PARTICULARS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition as far as Dr. Stein knows.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45522 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45522

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Dr Jos Hosp. ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bachman

(a) RESIDENCE. No. Christopher Ave Hamilton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: wh.

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 6th 20

7 AGE: Years ... Months ... Days 1

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dr Jos. Hosp.

PARENTS

10 NAME OF FATHER Geo - Bachman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary E Rapp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Geo Bachman

(Address) Hamilton Md

15 Filed AUG 8 1920, 19 ... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1920

17 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...,

that I last saw h im alive on Aug 7th, 1920,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) J. J. Dunegan, M. D.

, 19 (Address) 14 East Preston Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemtry — DATE OF BURIAL: Aug 9 1920

20 UNDERTAKER: William Cook — ADDRESS: Fox & North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. Physician's Statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Extract from Statement of CAUSE OF DEATH in plain terms, so that it may be used as a check of certificates. See instructions on back of certificates. SIGNATURE OF PHYSICIAN is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45523

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45523

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Myrtle ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary H. Bowers

(Residence in Baltimore: No. 1215 Myrtle ave ST.; 63 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR ~~RACE~~, B.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, [illegible] (Month) (Day) 1857 (Year)

7-AGE, 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic 070

9-BIRTHPLACE, (State or Country), unknown

PARENTS.

10-NAME OF FATHER, [illegible] Weaver

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis Watkins

(Address) 1215 Myrtle ave

15- Filed AUG 8 1920, 191.. Robert P. Harrison, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 5 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 5 1912, to Aug 5 1920 that I saw h[illegible] alive on Aug 4 1920 and that death occurred, on the date stated above at 3:30 a m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. 2 mos. ds.

(Signed) C. H. Jones M. D.

Aug 8, 1920 (Address) 714 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Aug 7, 1920

20-UNDERTAKER Wm Geo H Hunter

ADDRESS 406 W Conway St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY: [illegible] is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 45524

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45524

CERTIFICATE OF DEATH.

1720

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 E. Eager St.: 10 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Leonard

(a) RESIDENCE. No. 521 E. Eager St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 9 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catharine P. Murray

6 DATE OF BIRTH (month, day, and year) Oct. 22, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Warden - Maryland

(b) General nature of industry, business, or establishment in which employed (or employer) Penitentiary

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER John Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Susan Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Mildred Leonard

(Address) 521 E. Eager Street

15 Filed AUG 8 1920

16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August - 5 - 1920

17 I HEREBY CERTIFY, That I attended deceased from June - 5, 1920, to August - 5, 1920, that I last saw him alive on August - 5, 1920, and that death occurred, on the date stated above, at 10.10 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation - Passive congestion of viscera

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

Toxic Influenza (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William F. Schwartz, M. D.

8/7. 1920 (Address) 1200 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	8/9 1920
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful to see that information should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements should be made. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45525

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45525

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1829 Clifton Ave. ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank C. Krueger

(a) RESIDENCE. NO. 1829 Clifton Ave ST. 13th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Mary C. Krueger

6 DATE OF BIRTH (month, day, and year) Nov 21, 1863

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
57	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Gro. Blume & Sons

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Krueger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary C. Krueger

(Address) 1829 Clifton Ave

15 Filed AUG 8 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION should be stated EXACTLY what it is. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6 1920

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1920, to Aug 6, 1920, that I last saw him alive on Aug 6, 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

From (duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Lymph glands

(Signed) Wm. Grant, M. D.

, 19 (Address) 1925 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Aug. 9 1920
20 UNDERTAKER	ADDRESS
Henry W. Meads & Son	805 N. Calvert St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45526 HEALTH DEPARTMENT—CITY OF BALTIMORE 104 D45526

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 E 22½ St. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Harris

(a) RESIDENCE. No. 412 E 22½ St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 15+ ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Clarence Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Lena M Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Lena Marshall

(Address) 412 E 22½ St

15 Filed AUG 9 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1920

17 I HEREBY CERTIFY, That I attended deceased from July 23rd 1920, to Aug 7th 1920.

that I last saw him alive on Aug 6th 1920.

and that death occurred, on the date stated above, at 10:50 a m.

The CAUSE OF DEATH* was as follows:

Marasmus & Chronic Gastritis and Diarrhea

Along with Dentition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Gastritis & Diarrhea (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Diagnosis

(Signed) Chas. Hall M. D.

. 19 (Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Aug 9 1920
20 UNDERTAKER	ADDRESS
Joseph A Turrell	2314 Druid

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS SHOULD BE CAREFUL. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45527

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45527

CERTIFICATE OF DEATH.

1042

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1514 Aliceanna ST. D WARD)

2-FULL NAME Stanislaw Bednarczyk

(a) RESIDENCE. NO. 1514 Aliceanna ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 23-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Bednarczyk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Stanislawa Marciniak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Bednarczyk
(Address) 1514 Aliceanna

15 Filed AUG 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 5th 1920 to Aug 7th 1920

that I last saw him alive on Aug 5th 1920

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

(duration) ....yrs. ....mos. 5 ....da.

CONTRIBUTORY (Secondary) Same

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Jacob L Ulenson M. D.

19 (Address) 30 S Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary.	Aug 9 1920
20 UNDERTAKER	ADDRESS
Mrs Frankowski	168 Caden

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIAN'S NAME should be stated EXACTLY. PHYSICIAN'S ADDRESS should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION of deceased

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 45528

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45528

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2409 Fait ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaw Tymoszewski

(a) RESIDENCE. NO. 2409 Fait ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 8 mos. 9 ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 29-1915

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 100

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Antoni Tymoszewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Feliks Ostrowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Antoni Tymoszewski
(Address) 2409 Fait Ave

15 FILED AUG 9 1920 E. H. Grose Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 5, 1920, to Aug. 7, 1920, that I last saw him alive on Aug. 7, 1920, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) — yrs. — mos. 24 ds.

CONTRIBUTORY (Secondary) acidosis

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edward Novak, M. D.

19 (Address) 821 N. Patt. Pk. Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Aug 10 1920
20 UNDERTAKER Wm. F. Fiaskowski	ADDRESS 1618 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S name and address should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D45529 55 D45529

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frieda Kaufman

(Residence in Baltimore: No. 12 Irving Place St.; 1 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, May 15, 1919 (Month) (Day) (Year)

7-AGE, 1 yr 5 mon 13 da. 14 yrs. 14 mos. da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Meyer Kaufman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Lena Truman

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Levin

(Address) 1411 Eutaw

15- Filed AUG 9 1920 C. H. Grese, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 8, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 2nd 191, to Aug. 8th 1920, that I saw her alive on Aug. 8th 1920, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica.

(Duration) yrs. mos. 21 da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) B. Jacks M. D.

(Aug. 8th, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Workmen's Circle DATE OF BURIAL, 8/9/1920

20-UNDERTAKER Jack Levin ADDRESS 1411 Eutaw

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 45530 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45530

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1445 Hanburg ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur Dauphney

(a) RESIDENCE. NO. 1445 Hanburg ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 7 mos 22 ds

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIAN'S NAME should be stated EXACTLY. PHYSICIAN'S address should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edgar Dauphney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nannie Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edgar Dauphney

(Address) 1445 N. Hanburg St

15 FILED AUG 8 1920 C. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-8- 1920

17

I HEREBY CERTIFY, That I attended deceased from August 7, 1920, to August 8, 1920, that I last saw h alive on August 8, 1920, and that death occurred, on the date stated above, at 24 m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bad Food Theat

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Rupert Drain, M. D.

(Address) 1127 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Aug 9 1920
20 UNDERTAKER	ADDRESS 1140 W.
Brown & Rupert	Lexington St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45531 HEALTH DEPARTMENT—CITY OF BALTIMORE D45531

43

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 823½ Harford Ave ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Smith

(a) RESIDENCE. NO. 823½ Harford Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or WIFE of) the late Patrick Smith

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	68	—	.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Corcoran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna McDermott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Smith (Son)
(Address) 823½ Harford Ave

15 Filed AUG 3 1920 19 C. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1 1919 to Aug. 2 1920.
that I last saw her alive on Aug. 2 1920.
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:

Cancer of breast

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 1919

Was there an autopsy? No

What test confirmed diagnosis? Microscopical

(Signed) F. E. Bumstead M. D.

1920 (Address) 1531 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug 11 1920

20 UNDERTAKER ADDRESS

Henry Koeck & Son 1301 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45532 HEALTH DEPARTMENT—CITY OF BALTIMORE D45532

CERTIFICATE OF DEATH. 142

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mercy Hosp. St.: 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Fred Eisenberger

(a) RESIDENCE. No. 250 S. Chester St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) June 4th

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	52	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Eisenberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elz ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr Geo Eisenberger
(Address) #225 S Chester St.

15 Filed AUG. 9 1920
C. H. Grosa Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/1 1920

17 I HEREBY CERTIFY, That I attended deceased from 8/6, 1920, to 8/7, 1920, that I last saw him alive on 8/7, 1920, and that death occurred, on the date stated above, at 1 2, 10 a.m.

The CAUSE OF DEATH* was as follows:

Gen Gangrene of Perineum

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emma D. Rudy M. D.

8/9, 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Aug 10 1920

20 UNDERTAKER: Peter Nicolaus — ADDRESS: 2046 Easter

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS ... mation should be carefully supplied. AGE should be stated EXACTLY. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 45533

HEALTH DEPARTMENT—CITY OF BALTIMORE

105 D 45533

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 223 S Parrish ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Davis

(a) RESIDENCE. No. 223 S. Parrish ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9/1/15

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Clarence Heath

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Ida Barnes

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Ida. Barnes (Address) 223 S. Parrish St.

15 Filed AUG 2 1920 C. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/1/20 19

17 I HEREBY CERTIFY, That I attended deceased from 8/3/20, 19, to 8/1/20, 19, that I last saw h[illegible] alive on 7/4/20, 19, and that death occurred, on the date stated above, at 2 a/m.

The CAUSE OF DEATH* was as follows:

Has Colitis

History 2 wks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Bernard J. Fay, M. D.

8/5, 1920 (Address) 910 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	8/6/1920
20 UNDERTAKER	**ADDRESS**
Charles B. Jones	211 N. Pine St

N. B.—WRITE PLAINLY, WITH UNFADING INK. Information should be stated EXACTLY. Information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45534 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ 15-D45534

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1602 Lancaster ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME YANINA FIDRYCH,

(a) RESIDENCE. NO. 1602 Lancaster ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 26-1920.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant, 100

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.,

PARENTS

10 NAME OF FATHER Frank Fidrych,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Jozefa Marzelowska,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Frank Fidrych, (Father)

(Address) # 1602 Lancaster Street

15 Filed AUG 9 1920 C. H. Gresh Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) AUG 8- 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 6 , 19 20. to Aug 8 , 19 20, that I last saw h alive on Aug 8 , 19 20, and that death occurred, on the date stated above, at 11.00 A- m.

The CAUSE OF DEATH* was as follows:

Congenital Weakness

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? N.A.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L Wahlen, M. D.

Aug 9, 1920 (Address) 16 Bel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	Aug 9" 1920
20 UNDERTAKER	ADDRESS
M J. Sadowski.	705 S Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be given in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45535 D 45535

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital St.; 14 WARD) 105 REGISTERED NO. C

2-FULL NAME Cornelia Cowbs

(Residence in Baltimore: No. 1413 Mc Culloh St.; (If death occurred in a hospital or institution, give its NAME instead of street and number and add one No. 18.)

(Age: 3 yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female male

4-COLOR OR RACE. Color

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Child

6-DATE OF BIRTH, Aug 24 (Month), (Day), 1917 (Year)

7-AGE, 3 yrs. — mos. — da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... child
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER, Chase Cowbs.

11-BIRTHPLACE OF FATHER (State or Country), md.

12-MAIDEN NAME OF MOTHER Daisy Curtis

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daisy Curtis

(Address) 1413 Mc Culloh St

15- Filed AUG 9 1920, 191.... C. H. Cress Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 7 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 6 1920, to Aug 7 1920, that I saw h-r alive on Aug 6 7 1920, and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH was as follows:*

Acute Enteritis

(Duration) yrs. 1 mos. 4 da.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 2 da.

(Signed) [illegible] M. D.

Aug 7, 1920 (Address) 1413 Mc Culloh St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 1 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? 1413 Mc Culloh St

Former or usual residence " "

19-PLACE OF BURIAL OR REMOVAL, Woodlawn — DATE OF BURIAL, Aug 9, 1920

20-UNDERTAKER Edward Ringgold — ADDRESS 1463 Pine St

N. B.—Every item of information should be carefully supplied. Accurate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

143 139 45536 — X 45 2 45536

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen Hudgins.

(a) RESIDENCE. No. 1820 Baltimore St. Norfolk Va.
(Usual place of abode) WARD.
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) Jennie Hudgins

6 DATE OF BIRTH (month, day, and year) June 10 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal. Trimmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Fields Hudgins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Low Eva.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant J. H. Brooks (Address)

15 AUG 9 1920.

C. H. Grose Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7. 1920

17

I HEREBY CERTIFY, That I attended deceased from July 16, 1920, to Aug 7-, 1920

that I last saw h. alive on Aug 7-, 1920

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of the Lung.

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of None

Was there an autopsy? No.

What test confirmed diagnosis? Exam of tentative nodule

(Signed) Schumacher M. D.

, 1920 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfork Va,	Aug 8th 1920
20 UNDERTAKER	ADDRESS
Harry A. Godfrey	1725 Orleans St

N. B.—WRITE PLAINLY, with ... supplied. AGE should be carefully supplied. Exact statement of ... mation should be carefully supplied. AGE should be stated EXACTLY. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D45537 — 1042D45537

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1500 N. Gay ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Chambers

(Residence in Baltimore: No. 1506 N Gay St.; 16 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	

6-DATE OF BIRTH, July 30, (Month) (Day) 1904 (Year)

7-AGE, 16 yrs. 0 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) ——

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER Albert J Chambers

11-BIRTHPLACE OF FATHER (State or Country), Baltimore md

12-MAIDEN NAME OF MOTHER Marie A Dannenhauer

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert J Chambers jr

(Address) 1506 N Gay St

15- Filed AUG 9 1920, 191.... C. H. Gresse Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 7, (Month) (Day) 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 2, 1920, to Aug 7 1920, that I saw h[illegible] alive on Aug 6 1920, and that death occurred, on the date stated above, at 6.9 a.m.

The CAUSE OF DEATH* was as follows:

Mal-Nutrition

(Duration) 1 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Measles

(Duration) yrs. 2 mos. 24 ds.

(Signed) J. William Travis M. D.

Aug 9, 1920 (Address) 1497 W Lay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Vincents Cemetery — DATE OF BURIAL, Aug. 9, 1920

20-UNDERTAKER Robt J Turner Sons — ADDRESS 1422 W Pratt

N.B.—Every item of information should be carefully supplied, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

845538 HEALTH DEPARTMENT—CITY OF BALTIMORE 845538

CERTIFICATE OF DEATH. 30

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1919 Mc Elderry ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Gannon

(a) RESIDENCE. No. 1919 Mc Elderry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 15 mos. 27 ds. How long in U. S., if of foreign birth? yrs. 15 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10 May 1919

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	15	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jas P. Gannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Agnes Stella Kaufman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs. Blanche Gannon

(Address) 2009 Fairmount Ave

15 Filed AUG. 9 1920 C. H. Grose, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 Aug. 1920

17 I HEREBY CERTIFY, that I attended deceased from 4 Aug. 1920. to 7 Aug. 1920. that I last saw him alive on 4 Aug. 1920. and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

Tubercular meningitis

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal puncture

(Signed) Bartus J. Baggott M. D.

, 19 (Address) 1201 Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer. DATE OF BURIAL Aug 9th 1920

20 UNDERTAKER Geo. W. Fink & Son, ADDRESS 811 N. Howard St

Funeral Directors & Embalmers

N. B.—WRITE PLAINLY, WITH INK. ALL QUESTIONS should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D45539

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45539

CERTIFICATE OF DEATH. Hofstetter

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 A. St ST.; WARD) 27

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Fredrick Hofstetter

(Residence in Baltimore: No. 216 A St Roland Park 2 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, Feb 24, 1865 (Month) (Day) (Year)

7-AGE, 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Policeman
(b) General nature of industry, business, or establishment in which employed (or employer). 061

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Joseph Hofstetter

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Margaret Einsfeldt

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence E. Hofstetter

(Address) 216 A St

15-

Filed AUG 9 1920, 191 C. H. Gross Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 7, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 12 1920, to Aug. 7 1920, that I saw him alive on Aug. 7 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(Duration) 2 yrs. 6 mos. 26 ds.

CONTRIBUTORY (Secondary) Mutual Reserve Assn

(Duration) 2 yrs. 6 mos. 26 ds.

(Signed) M. Dixon Porter M. D.

Aug. 7, 1920 (Address) 422 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Aug 10, 1920

UNDERTAKER Chenowith Son — ADDRESS Chestnut Ave

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 45540

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 45540

CERTIFICATE OF DEATH.

104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 Thames St ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Czeslawa Jagodzinska

(Residence in Baltimore: No. 1620 Thames ~~1620 Thames~~ St.; ....yrs., 11 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	

6-DATE OF BIRTH, April (Month) 2 (Day) 1920 (Year)

7-AGE, ...yrs. 4 mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Marion Jagodzinski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Sophia Bartosia

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marion Jagodzinski

(Address) 1620 Thames St

15- Filed AUG 9 1920, 191..... C. H. Grese Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 8 (Day), 1920 (Year)

I HEREBY CERTIFY, That I attended deceased from August 6 191.., to August 8 191.., that I saw h.. alive on August 8 191.., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

acute Dio-colitis

(Duration) ....yrs. 6 days mos. 2 days

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Frank A. Finnegan M. D.

August 9, 1920. (Address) 245 Wash

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	August 9, 1920
20-UNDERTAKER	ADDRESS
John In Weber	1803 Bank St

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45541 D45541

CERTIFICATE OF DEATH.

REGISTERED NO. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 S. Regester ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Wm Kaulbach

(Residence in Baltimore: No. 420 S. Regester St.; yrs. 7 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, September 20, 1912
(Month) (Day) (Year)

7-AGE, yrs. 7 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Walter Kaulbach

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Emilie Kuhlberg

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emilie Kaulbach

(Address) 420 S. Regester St.

15-

Filed AUG 9 1920 C. H. Gross
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 8, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 7 1920, to August 8 1920, that I saw him alive on August 8 1920, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 6 ds.

(Signed) [illegible] M. D.

8-8, 1920. (Address) 422 S. Regester

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus — DATE OF BURIAL, August 9, 1920

20-UNDERTAKER John A Weber — ADDRESS 1803 Bank St

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D45542

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45542.

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH St. Agnes Hosp - REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No ..... ST.: 20 WARD)

2-FULL NAME Mrs Maggie Miller

(a) RESIDENCE. No..... 2035 Frederick Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Wh -

5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. J. Miller

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	—	—	

8 OCCUPATION OF DECEASED Housewife

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Husband (Address) 2035 Frederick Ave

15 Filed AUG 9 1920 C. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/7/ 1920

17 I HEREBY CERTIFY, That I attended deceased from 8/4/20, 19 , to 8/7/20, 19 , that I last saw h[illegible] alive on 8/5/20, 19 , and that death occurred, on the date stated above, at 2.15 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

not known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis - Coma -

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory tests

(Signed) W. S. Caldwell, M. D.

, 19 (Address) St. Agnes Hosp -

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Aug 10 1920

20 UNDERTAKER Geo. L. Schwab & Bro 2101 Eutaw Ave — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

245543 — 79 — 245543

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.: 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laurence Arnold

(a) RESIDENCE. No. 2725 Pennsylvania Ave. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs. Marie Arnold

6 DATE OF BIRTH (month, day, and year) July 13-1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37 years		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) United Ry & Elec Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Edgar F. Arnold.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER F. A. Bourke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. Marie Arnold
(Address) 2725 Penna Ave

15 Filed AUG 9 1920, 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 20 to Aug. 8, 20, that I last saw him alive on Aug 8, 20, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic adhesive Pericarditis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocardial Insufficiency

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy?

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Howard Kelly, M. D.

8/8, 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery — DATE OF BURIAL Aug 11 20

20 UNDERTAKER Putnam & Gore — ADDRESS 1725 Lafayette Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D45544 HEALTH DEPARTMENT--CITY OF BALTIMORE D45544

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C 45

CITY OF BALTIMORE (No. 905 Eutaw Ave ST. 9 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Albert Borsch

(Residence in Baltimore: No. 905 Eutaw Ave. St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~ (Write the word): Married

6 DATE OF BIRTH: October 14, 1883 (Month) (Day) (Year)

7 AGE: 36 yrs. 10 mos. 6 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Printer 063
(b) General nature of industry, business, or establishment in which employed (or employer): News paper

9 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Fredrick John Borsch

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louise Berger

13 BIRTHPLACE OF MOTHER (State or country): Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H B Wolf M.D.

(Address) 113 W. Franklin

15 C. H. Grese. REGISTRAR

Filed AUG 9 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: August 8, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 12, 1919, to, August 8 1920, that I saw him alive on August 7, 1920, and that death occurred, on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:

Sarcoma of Testicle &
Metastasis of Post Peritoneal Glands

(Duration) yrs. 9 mos. ds

Contributory (SECONDARY): Metastasis of Peritoneal Glands & Lungs

(Duration) yrs. mos. ds.

(Signed) H B Wolf 113 W Franklin St.

8/8, 1920 (Address) H B Wolf M.D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cedar Hill — DATE OF BURIAL: Aug 11, 1920

20 UNDERTAKER: William Cook — ADDRESS: 502 E. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45545 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45545

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2559 Mc Cullough ST.: 13 WARD)

REGISTERED No. 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan H. Langdon.

(a) RESIDENCE. No. 2559 Mc Cullough ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of E. Rose Langdon.

6 DATE OF BIRTH (month, day, and year) Sept 6 - 1843

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter. Ret'd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert A. Langdon.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Jane Copeland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant E. Rose Langdon
(Address) 2559 McCullough St.

15 Filed AUG 9 1920 . 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1920, to Aug 8, 1920, that I last saw him alive on Aug 8, 1920, and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Chr. myocarditis and arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ex haemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert W. Mifflin for Geo. C. Price, M. D.

Aug. 19 20 (Address) 1016 Madison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	Aug 11—1920
20 UNDERTAKER Wm. Cook	ADDRESS 502 E Monument Ave.

...mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45546 HEALTH DEPARTMENT—CITY OF BALTIMORE 19-003 D 45546

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital St.. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Gaddess.

(a) RESIDENCE. NO. St Josephs Hospital ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/2/1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
84		5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Mil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Alexander Gaddess

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Margaret Nestas

13 BIRTHPLACE OF MOTHER (city or town) C C Co Md
(State or country)

14 Informant Edward Gaddess
(Address) 225 N Calhoon St

15 Filed AUG 9 1920 19 G. H. Crews Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/9/1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1914, to Aug 9, 1920, that I last saw h~~im~~ alive on Aug 9, 1920, and that death occurred, on the date stated above, at 12.30 m.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Rheumatism

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) F. C Mumbar, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	August 11 1920
20 UNDERTAKER Henry Jenkins & Son Co	ADDRESS Orchard & McCulloh Sts

nation should be carefully supplied. AGE should be properly classified. Exact Statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45547

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45547

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3512 Frederick Ave; ST.. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME None

(a) RESIDENCE. NO. 3512 Frederick Ave; ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 7th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

000

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James E Donnelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Anna Eydelloth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant James E. Donnelly (Address) 3512 Frederick Ave.

15 Filed AUG 9 1920 C. H. Greer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 19 20

17

I HEREBY CERTIFY, That I attended deceased from Aug 7 , 1920 , to Aug 9 , 1920 ,

that I last saw him alive on Aug 8 , 1920

and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edd Brumpton, M. D.

8/9/20 (Address) 517 Scott St Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug 9th 1920
20 UNDERTAKER C. W. Dill	ADDRESS 3109 Frederick Ave.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Examination of OCCUPATION is very important. See instructions on back of certificates.

D45548

HEALTH DEPARTMENT--CITY OF BALTIMORE

D45548

CERTIFICATE OF DEATH

150

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 145-5 Hale ST.: 24 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Bernard White

(Residence in Baltimore: No. 145-5 Hale St. St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH August 4, 1920
(Month) (Day) (Year)

7 AGE ..... yrs. ..... mos. 4 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9 BIRTHPLACE (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph White

11 BIRTHPLACE OF FATHER (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Catherine Frazel

13 BIRTHPLACE OF MOTHER (State or country) Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs White

(Address) 145-5 Hale St

15

Filed AUG 9 1920 G. H. Cress

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 9th, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4th, 1920, to Aug 9th 1920, that I saw him alive on Aug 8, 1920, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Congenital deformity & paralysis (Spina bifida) 1 of Legs

(Duration) yrs. mos. 7 ds

Contributory (SECONDARY) Convulsions 3 hrs.

(Duration) yrs. mos. ds.

(Signed) Mary N. Byrne M. D.

Aug 9th, 1920 (Address) 510 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death				In the State			

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Holbrook & Co

DATE OF BURIAL 8/7, 1920

UNDERTAKER Wm Pearl

ADDRESS 115 E Hoffman

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.45549 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45549

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. Genl. Hosp. ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Ashcock Beaton

(a) RESIDENCE. NO. 430 N. Fremont ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 5, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	17 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 300

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Raymond Beaton

11 BIRTHPLACE OF FATHER (city or town) Ryegate
(State or country) Vermont

12 MAIDEN NAME OF MOTHER Alma Miller

13 BIRTHPLACE OF MOTHER (city or town) Balto,
(State or country) Md.

14 Informant Raymond Baton
(Address) 430 N. Mont St

15 Filed AUG 9 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 5 1920, to Aug. 9 1920, that I last saw h.. alive on Aug. 9 1920, and that death occurred, on the date stated above, at 7:45 A. m.

The CAUSE OF DEATH* was as follows:

Premature Labor

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Inanitions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred B. Smith M. D.

. 19 (Address) M. G. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 10 1920

20 UNDERTAKER Geo. Weber & Son ADDRESS 2503 Edmondson Ave

mation should be carefully supplied. Any ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Ex... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45550 1920 44 117

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45550

120

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 S Edmondson St.; 6 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd Moore

(a) RESIDENCE. No. Waterbury Conn St.; Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W	Married

5a If married, widowed, or divorced (or) WIFE of Mary C. Moore

6 DATE OF BIRTH (month, day, and year) Jan 13. 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Construction 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thos H Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant (Address) Mary E Moore 113 S Edmondson Ave

15 Filed AUG 9 1920. Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1920

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1920, to Aug 9, 1920.

That I last saw h.. alive on Aug 6, 1920.

and that death occurred, on the date stated above, at 1614 o. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hight Blood Pressure (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. C. Hearn, M. D.

Aug 7, 1920 Address) 2600 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug. 9 1920
20 UNDERTAKER Wm H Hayden & Sons	ADDRESS 3, 8 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement must be complete. TION is very important. See instructions on back of certificates.

Spec.—6-24-14—M. & T.—2000 Blks.

D. 45551

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45551

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Monnick

(Residence in Baltimore: No. Nursery & Child's Hospital St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	

6-DATE OF BIRTH, June 16, 1920
(Month) (Day) (Year)

7-AGE, ... yrs. 1 mos. 21 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Harry Monnick.

11-BIRTHPLACE OF FATHER (State or Country), Unknown.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Hutton

(Address) Nursery & Child's Hosp.

15-

Filed AUG 9 1920, Robert P. Harrison, M.D.
Registrar.

Burial Permit Clerk.

17417

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 5, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 1, 1920, to August 5 1920, that I saw him alive on August 5 1920, and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

(a) Marasmus

(Duration) ..... yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion Embolism

(Duration) ..... yrs. ..... mos. 3 hr

(Signed) Manuel L. Gerber M. D.

Aug. 6., 1920. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. 5 ds. In the State .... yrs. 1 mos. 21 ds.

Where was disease contracted, if not at place of death? Nursery & Child's Hospital

Former or usual residence Nursery & Child's Hospital

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL DATE OF BURIAL, ..., 191...

20-UNDERTAKER Commissioner Health. ADDRESS AUG. 7 1920

Har. Wm. E. WOODALL

N.B.—Every item of CAUSE OF DEATH in plain terms, so that it may be properly classified. Each important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

20.45552 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.45552

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 N Collington Ave ST.; 1 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred G Lazowska

(Residence in Baltimore: No. 922 N Collington Ave St.; ..... yrs., 10 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Oct 10, 1920
(Month) (Day) (Year)

7-AGE, ... yrs. 10 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Joseph Lazowska

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Julia Muchna

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Lazowska

(Address) 922 N. Collington Ave

15-

AUG 9 1920 Robert P. Harrison, ...
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 8, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1920, to Aug 8 1920, that I saw h alive on Aug 1 8 1920, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea,

..... (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Malnutrition Cardiac Failure

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) William J. Reese M. D.

Aug 8, 1920 (Address) 504 Hennen Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer | DATE OF BURIAL, Aug 10, 1920

20-UNDERTAKER Frank Brachbill | ADDRESS 1906 Bank

N.B.—EVERY ITEM in this CERTIFICATE OF DEATH must be filled in plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45553

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45553

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olivia Webster

(a) RESIDENCE. No. 1601 Madison ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Jas. K Webster

6 DATE OF BIRTH (month, day, and year) Aug 6 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	0	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 837

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Albert Alley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania Dealer

12 MAIDEN NAME OF MOTHER Mary E Eaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant James A. Webster
(Address) 1601 Madison Ave

15 Filed AUG 9 1920 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 9. 1920.

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1920, to August 9, 1920

that I last saw h.r alive on Aug 8th, 1920

and that death occurred, on the date stated above, at 2.50 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Bladder

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 7th 1920

Was there an autopsy? No

What test confirmed diagnosis? Clinical Methods.

(Signed) [illegible], M. D.

8/9. 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cem. Roland Ave	Aug 11 1920
20 UNDERTAKER Wm J McKeever & Sons	ADDRESS Morgan & Pa

mation should be carefully supplied, so that it may be properly
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 045554 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.45554

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2736 W. Mosher ST.; 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma M. Wade

(a) RESIDENCE. NO. 2736 W Mosher ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. 3 mos. 20 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 18-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	14	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co

PARENTS

10 NAME OF FATHER Harry A Wade

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co

12 MAIDEN NAME OF MOTHER Carrie Hogge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

14 Informant Carrie Lehner
(Address) 2736 W Mosher St

15 Filed AUG 9 1920 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1920, to Aug 7, 1920, that I last saw her alive on Aug 7, 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis (duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Ury. sed.

(Signed) B. F. Lynch, M. D.

8/8, 1920 (Address) 1707 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 12 1920
20 UNDERTAKER	ADDRESS
W. J. Eschmeyer & Co	Balto

mation should be given in these columns, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D.45555 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45555

CERTIFICATE OF DEATH.

174

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1925 E Charles ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lakefest. Adams.

(Residence in Baltimore: No. 1804 E Charles St. St.: 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M | 4-COLOR OR RACE, W | 5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, Aug 28 1882 (Month) (Day) (Year)

7-AGE, 37 yrs. 11 mos. 10 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Truck Driver
(b) General nature of industry, business, or establishment in which employed (or employer) 1 1 023

9-BIRTHPLACE (State or Country) Dorchester Co. Md

PARENTS.

10-NAME OF FATHER William H. Adams

11-BIRTHPLACE OF FATHER (State or Country) Dorchester Co. Md.

12-MAIDEN NAME OF MOTHER Eva. Smith

13-BIRTHPLACE OF MOTHER (State or Country) Dorchester Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Adams

(Address) 1804 E. Charles

15- Filed AUG 9 1920, 191.... Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 8 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows: Concussion of Brain accident (Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exposure (Duration) 0 yrs. 0 mos. 1 ds.

(Signed) J. C. Staley (Coroner) M. D.

....., 191... (Address) 1425 E Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Fishing creek Dorchester Co Md. | DATE OF BURIAL, 8/10 1920

20-UNDERTAKER J. F. M. Cully | ADDRESS 130 E. Fort.

N.B.—Every item of information should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45556 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45556

CERTIFICATE OF DEATH. 43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 N. Broadway; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice F. Gray

(a) RESIDENCE. No. 715 N. Broadway ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Wade H Gray

6 DATE OF BIRTH (month, day, and year): Sept 23 - 1875

7 AGE — Years: 44 — Months: 11 — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Alexander Frederick
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md
12 MAIDEN NAME OF MOTHER: Elinor Boos
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Sydney Gray
(Address): 715 N. Broadway

15 Filed ..... 19 .....
Robert P. Harrison,
Registrar

AUG 9 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 00 1919 to Aug 7 1920, that I last saw her alive on Aug 7 1920, and that death occurred, on the date stated above, at 4.35 p. m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Alf L Gage, M. D.

, 19 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Aug 11 - 1920

20 UNDERTAKER: William Cook — ADDRESS: 505 E North

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

845557 ✓ D 45557

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1603 Young ct ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Gibson

(a) RESIDENCE. No. 1603 Youngs ct ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Same yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ellen Gibson
(Address) 1603 youngs ct

15 Filed AUG 10 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1920

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1920. to Aug 7, 1920.
that I last saw h[illegible] alive on Aug 7, 1920.
and that death occurred, on the date stated above, at 7, 20 P. m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Valvular heart disease

Endocarditis (duration) 1 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Fisher, M. D.

8-9 1920 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Evergreen Cem.	Aug. 10 1920
20 UNDERTAKER	ADDRESS
Thos J. G. Locks	1382 Jefferson

mation should be carefully supplied. Items must be properly classified. Blank spaces may be CAUSE OF DEATH in plain terms, so that it may be correctly classified. Blank spaces may be TION is very important. See instructions on back of certificates.

D 45558 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45558

114

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Memorial Hospital ST.: 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H. Myers

(Residence in Baltimore: No. 1927 Madison Ave St. 2 yrs., 10 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	white	widower

6-DATE OF BIRTH. January 31, 1865 (Month) (Day) (Year)

7-AGE. 55 yrs. 7 mos. 8 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. R.R. clerk
(b) General nature of industry, business, or establishment in which employed (or employer). Claim Dept.

9-BIRTHPLACE, (State or Country). Ohio

PARENTS.

10-NAME OF FATHER. Jacob Myers

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Kathrine ?

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Given on admittance to Hospital

(Address) .....

15-

Filed AUG 10 1920 C. H. Crose Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. August 8, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture of gall bladder
Cholelithiasis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Senile Peritonitis

(Duration) ....yrs. ....mos. 2 ds.

(Signed) J. D. Hennessy M. D. (Coroner.)

Aug. 9, 1920 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the U. S. A. State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence. 1927 Madison Ave Bal

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Lima Ohio	Aug. 12th 20
20-UNDERTAKER Geo Schillinger & Sons	ADDRESS Mourning Augusta

N. B.—Every item of information must be given, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, as that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45559 HEALTH DEPARTMENT—CITY OF BALTIMORE D45559

CERTIFICATE OF DEATH. 108

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. South Balto Gen. Hospital WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Lowman

(a) RESIDENCE. NO. 2038 E. Balto St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Raymond Lowman.

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westpoint, Va.

PARENTS

10 NAME OF FATHER Michael Long

11 BIRTHPLACE OF FATHER (city or town) Wilmington, (State or country) Delaware.

12 MAIDEN NAME OF MOTHER Annie Free

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) Maryland

14 Informant Francis Long (Address) 2038 E Balto St

15 Filed AUG 31 1920 C. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-7-1920

17 I HEREBY CERTIFY, That I attended deceased from 7-23-20, 1920, to Aug. 7, 1920, that I last saw her alive on Aug. 7, 1920, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Appendicitis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 19 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of 7-23-20

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) J. T. Conte Jr., M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents Cem	8/10/1920
20 UNDERTAKER	ADDRESS
Jno. J. Lahey & Sons	1518 Druid Hill Ave

mation should be carefully supplied. Exact statement of occupation may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45560

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D45560

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2222 E. Fairmount Ave ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Barnickel

(a) RESIDENCE. No. 2222 E. Fairmount Ave ST., 6 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Barnickel

6 DATE OF BIRTH (month, day, and year) Sept 4-1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hirschfeld. Bavaria. (Ger.)

PARENTS

10 NAME OF FATHER John Neubauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Margaret Neubauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Barnickel (Address) 2222 E. Fairmount Ave

15 Filed AUG 10 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 3rd, 1920, to Aug 7th, 1920

that I last saw h.. alive on Aug 6th, 1920

and that death occurred, on the date stated above, at 11.40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Elstrodt, M. D.

, 19 (Address) 607 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug. 11 1920
20 UNDERTAKER	ADDRESS
Lilly and Zeller	4035 W. North Ave

mation should be carefully considered, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.--8-24-14—M. & T.—2000 Bks.

D45561

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45561

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. Washington Road ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert H. Grace.

(Residence in Baltimore: No. Washington Road St. Timmins; ..... yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Infant

6-DATE OF BIRTH, Dec. (Month) 16 (Day), 1919 (Year)

7-AGE, ... yrs. 7 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 001

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Grace.

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Jamie Sapprunt

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Grace

(Address) Washington Road

15-

Filed AUG 10 1920 1919 G. H. Gross Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 9 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Aug 9 1920, that I saw him alive on Aug 8 1920, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar
Influenza

(Duration) 10 yrs. 10 mos. 01 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Raymond Stokes M. D.

Aug 9, 1920 (Address) Jarboe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Farmer or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Westen	Aug 10, 1920
20-UNDERTAKER	ADDRESS
John J. Fildes & Son	W. Fombard

N. B. Give CAUSE OF DEATH in plain terms, so that it may be understood by all. Especially important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45562

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45562

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 122 S Carrollton Ave ST.: 1 WARD)

2-FULL NAME Catharine McConnell

(a) RESIDENCE. No. 122 S Carrollton Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14th 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 800

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER James Connell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Quinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Edgar Connell
(Address) 122 S Carrollton Ave

15 Filed AUG 10 1920 G. H. Gresc Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-9- 1920

17 I HEREBY CERTIFY, That I attended deceased from August 1 1920 to August 9 1920, that I last saw him alive on August 7 1920, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Mal Nutrition

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Philip Lund Brand M. D.

1920 (Address) 1207 Columbus

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug 10 1920

20 UNDERTAKER John L Fields ADDRESS 1200 W Lombard

mation should be carefully supplied, so that it may be properly classified. Exact
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.---8-24-14---M. & T.---2000 Bks.

D 45563 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45563

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 Riggs ave, St.; 16 Ward)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas. H. A. Hill

(Residence in Baltimore: No. 1124 Riggs ave, St.; 57 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	Col	M

6-DATE OF BIRTH, ... (Month) ..... (Day), 1863 (Year)

7-AGE, 57 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Lab

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. F. Hill

(Address) 1124 Riggs Ave

15- Filed AUG 10 1920 191..... Registrar.

G. H. Crose

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 7 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1st 1920, to 8-6-20 191....., that I saw h..... alive on ..... 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. M. Chandler M. D.

8-9-20 191... (Address) 1524 E Hill ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Aug. 9, 1920
20-UNDERTAKER John H Toadvine	ADDRESS 142 Union St

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45564 ✓ 15 | 245564

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 Etterbein ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Collar Leroy King

(Residence in Baltimore: No. 212 Etterbein St.; yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M.	Colored	Single

6-DATE OF BIRTH, July 8th, 1920
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs. 1 mos. ....ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Albert King

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co Md.

12-MAIDEN NAME OF MOTHER Hattie Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Essex Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert King

(Address) 212 Etterbein St

15- FILED AUG 10 1920 G. H. Grese. Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 8, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 4 1920, to Aug 8 1920, that I saw him alive on Aug 4th 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John Houff M. D.

8/9, 1920. (Address) 1143 W Balto St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Aug 10 1920

20-UNDERTAKER Jno H Toadvine — ADDRESS 142 W. Hill St.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 45565 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 45565

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 753 Dover ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Murray

(a) RESIDENCE. No. 753 Dover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Murray

6 DATE OF BIRTH (month, day, and year) Jan 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	~~58~~ 58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Harriet Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Mamie Murray (Address) 753 Dover St

15 Filed AUG 10 1920 G. H. Gr... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1920

17 I HEREBY CERTIFY, That I attended deceased from July 29. 1920. to Aug 8. 1920. that I last saw her alive on Aug 3. 1920. and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Starvation

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. L. Hooper, M. D.

8-9, 1920 (Address) 1462 E. Lo...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Aug 11 1920
20 UNDERTAKER	ADDRESS
Jno. H. Toadvin	W. Hill St

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45566 HEALTH DEPARTMENT—CITY OF BALTIMORE D45566

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 N. Lakewood Ave ST.) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond W. Clayton

(a) RESIDENCE. No. 524 N. Lakewood Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 16 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Wm Clayton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Rena O'Donnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Rena Clayton

(Address) 524 N Lakewood Ave.

15 Filed AUG 10 1920, 19 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 19 20, to Aug 8, 19 20, that I last saw h[illegible] alive on Aug 8, 19 20, and that death occurred, on the date stated above, at 10:20 P.M.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Cook M. D.

8/9, 19 20 (Address) 413 N Washington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Aug 10th 1920
20 UNDERTAKER	ADDRESS
Geo. M. Fink & Son,	[illegible]

Funeral Directors & Embalmers.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45567

CERTIFICATE OF DEATH.

91-0 D45567

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 Leadenhall ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Jobs

(a) RESIDENCE. No. 1003 Leadenhall ST. 23 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Jobs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elnora Clash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Henry Jobs 1003 Leadenhall St

15 Filed AUG 10 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 7th 1920, to Aug 9th 1920, that I last saw h[illegible] alive on Aug 9th 1920, and that death occurred, on the date stated above, at 4:50 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no-

What test confirmed diagnosis? clinical

(Signed) J. Jay Borley M. D

8/9/ 1920 (Address) 908 S Shaph St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn X	Aug 11 1920
20 UNDERTAKER	ADDRESS
A. L. Brown & Son	1018 W. Mont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Indefinite terms, such as "Heart Failure," "Old Age," "Senility," "Exhaustion," "Convulsions," "Paralysis," "Cancer," "Tumor," "Abscess," "Blood Poisoning," "Septicemia," "Pyemia," "Uremia," "Meningitis," "Hemorrhage," "Tuberculosis," "Pneumonia," "Bronchitis," "Nephritis," "Colitis," "Enteritis," "Gastritis," "Peritonitis," "Appendicitis," "Hernia," "Intussusception," "Obstruction," "Ulceration," "Perforation," "Fracture," "Injury," "Accident," "Suicide," "Homicide," "Drowning," "Asphyxiation," "Burns," "Scalds," "Shock," "Hemorrhage," "Infection," "Septicemia," "Pyemia," "Uremia," "Meningitis

B82377.

Baltimore, Md., August 13, 1920.

I do hereby make oath that the date of birth and the age giv
on Baltimore City Health Department Certificate of Death # D-45567,
for Carrie Jobs, as January, 1920 and 8 months, is not correct and tha
same should be recorded as - date of birth - July 2, 1918, and the age
as 2 years, one month and 7 days.

Eleanor Jobes
Mother

Subscribed and sworn to before me this 13th day of August, 19

Reed Guthrie
Notary Pu

D45568 HEALTH DEPARTMENT—CITY OF BALTIMORE D45568

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 78

CITY OF BALTIMORE (No. 16 Regester St. ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Viola Williams

(Residence in Baltimore: No. 16 S Regester St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Negro

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 10 (Day), 1896 (Year)

7-AGE, 23 yrs. 1 mon. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Samuel Williams

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Louisa Clayton

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rich Brown

(Address) 1605 6 Lambard St

15- G. H. Grace

Filed AUG 10 1920, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 7 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute Alcoholism

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry P. Mosby M. D.
(Coroner.)

Aug 10 1920 (Address) 806 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Ashbury Cemetery	Aug 10 1920
20-UNDERTAKER	**ADDRESS**
Milton Davis	473 N Eden St

N. B.—Every item of information should be carefully given, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45569

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45569

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2205 McElderry ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Fowlers

(a) RESIDENCE. No. 2205 McElderry ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. 7 ds. How long in U. S., if of foreign birth? 24 yrs mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): 31 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
29		July	07	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor 04

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: unknown.

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Josiah Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Annie Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Addie Fowler

(Address): 2205 McElderry St.

15 Filed AUG 10 1920 G H Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 7 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug. 6 1920, to Aug 7, 1920.

that I last saw him alive on Aug 7, 1920.

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs

Tuberculosis of Lungs

(duration) yrs 7 mos. 6 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs

(duration) 1 yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. W Kennard, M. D.

Aug 8 1920 (Address) 708 Essex

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Aug 11 1920
20 UNDERTAKER	ADDRESS
Milton Davis	413 N Eden St

CAUSE OF DEATH in plain terms, so that it may be properly classified. THON is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45570

CERTIFICATE OF DEATH.

D45570

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3630 Sycamore Ave ST.; 13 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma J. Garteide

(Residence in Baltimore: No. 3630 Sycamore Ave St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. ..... (Month) Aug (Day) 1, (Year) 1861

7-AGE. 59 yrs. ..... mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... At Home (W)
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Co

PARENTS.

10-NAME OF FATHER, Philip Russell

11-BIRTHPLACE OF FATHER (State or Country), Balto Co

12-MAIDEN NAME OF MOTHER Sarah Butler

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. Schuman

(Address) 81 W. Lanwood Ave

15- Filed AUG 10 1920, 191.... G. H. Grace Registrar.

CAUSE OF DEATH in plain terms, so that it can be understood. Be particular and important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug (Month) 8 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Feb 1st 1919, to Aug 8 1920, that I saw her alive on Aug 8 1920, and that death occurred, on the date stated above, at 5 A.M. P. m.

The CAUSE OF DEATH* was as follows:

Encysted Papilloma of Ovary

.....

.....

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY Ascites

(Secondary) ..... (Duration) ..... yrs. 12 mos. ..... ds.

(Signed) C. B. Nourse M. D.

Aug 9, 1920 (Address) 2117 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Druid Ridge	Aug 11, 1920
20-UNDERTAKER	ADDRESS
H. S. Marshall	558 Fallsway

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45571 HEALTH DEPARTMENT—CITY OF BALTIMORE D45571

CERTIFICATE OF DEATH. 105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Miller

(a) RESIDENCE. No. 520 Brunswick ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Miller

6 DATE OF BIRTH (month, day, and year) July 23 - 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
53	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 037

(b) General nature of industry, business, or establishment in which employed (or employer) Home duties

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Saffran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany Germany

12 MAIDEN NAME OF MOTHER Katherine Reas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Balto Md

15 Filed AUG 10 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 24 1919, to Aug 5 1920, that I last saw her alive on Aug 5 1920, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

abt (duration) 0 yrs. 0 mos. 14 ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

abt (duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Md -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Aug 12 1920
20 UNDERTAKER John J Kavanaugh & Son	ADDRESS 901 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45572 HEALTH DEPARTMENT—CITY OF BALTIMORE D45572

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 Poplar Grove St. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Martin

(a) RESIDENCE. No. 2005 Poplar Grove St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 14, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pennsylvania
(State or country)

PARENTS

10 NAME OF FATHER William Fulton

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Ann Cannon

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs. Edith M. Oliver
(Address) 2005 Poplar Grove St.

15 Filed AUG 10 1920 G. H. Cross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1914, to Aug 10, 1920, that I last saw h[illegible] alive on Aug 10, 1920, and that death occurred, on the date stated above, at 3.45a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Mellus, M. D.

8/11/20 (Address) 2757 W Monroe av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia, Pa	8/12 1920
20 UNDERTAKER	ADDRESS
Henry W. Means & Son	605 N. Calvert St

CAUSE OF DEATH must be filled in. See instructions on back of certificates. TION is very important.

Pa. Penn R. R.

D 45573

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 45573

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 3147 Fredk ave ST. 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Henry Wagner

(Residence in Baltimore: No. 3147 Fredk ave St.: 5 yrs. — mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Even if it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 (SINGLE) MARRIED WIDOWED OR DIVORCED (Write this word): Married

6 DATE OF BIRTH: June 6, 1865 (Month) (Day) (Year)

7 AGE: 55 yrs. 2 mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Baker 003
(b) General nature of industry, business, or establishment in which employed (or employer): Boss

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: John Wagner

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna B. Wagner

(Address) 3147 Fredk: Ave:

15. Filed AUG 10 1920 G. H. Gresé. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug 9, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1920, to, Aug 9 1920
July 29/20 Aug 9 1920
that I saw him alive on
and that death occurred, on the date stated above, at 3 p m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. 7 ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P Gustav Dill M. D.

Aug 9, 1920 (Address) 1433 W Lombard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: Aug: 11 1920

20 UNDERTAKER: C. W. Dill — ADDRESS: 3109 Fredk: Ave:

Spec. 6-9-19 H. P. Co. 1000 Bks.

D 45574

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45574

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 Brooke Lane ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phillip Hamburger

(a) RESIDENCE. NO. 925 Brooke Lane ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 66 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis K. Hamburger

6 DATE OF BIRTH (month, day, and year) Dec 11th 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing Mfg

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Louis Hamburger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Dr L P Hamburger 1207 Eutaw Place

15 Filed AUG 10 1920 G. H. Cress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1920

17 I HEREBY CERTIFY, That I attended deceased from July, 1919, to Aug 10th, 1920, that I last saw h. ~~im~~ alive on Aug 9, 1920, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (ascending Colon)
(Clinical and X Ray Diagnosis)

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Hemicolitis (diarrhoea)

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & X Ray diag.

(Signed) Louis P. Hamburger, M. D.

, 19 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	Aug 12th 1920
20 UNDERTAKER	ADDRESS
Kurt Sondheim	418 N. Howard St

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

45575 104 & 45575

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin & Schroeder ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Frederick Jones

(Residence in Baltimore: No. Nursery & Child's Hospital St.: — yrs., — mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, W

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, July 18, 1920 (Month) (Day) (Year)

7-AGE, — yrs. — mos. 22 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Harry Jones

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Fischer

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Record

(Address) .....

15- C. H. Grese. Registrar.

Filed AUG 10 1920 191....

CAUSE OF DEATH to be plainly written. Every question important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 10, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1920 to Aug 10 1920, that I saw him alive on Aug 9 1920, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(Duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) pre-mature infant

(Duration) .... yrs. .... mos. .... ds.

(Signed) D. D. Singlar M. D.

Aug 10, 1920 (Address) 2002 E. Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 22 ds. In the State yrs. mos. 22 ds.

Where was disease contracted, if not at place of death? —

Former or usual residence University Hospital

19-PLACE OF BURIAL OR REMOVAL, Balto County — DATE OF BURIAL, Aug 10, 1920

20-UNDERTAKER Geo. C. Finley Fulton — ADDRESS [illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

D45576 HEALTH DEPARTMENT—CITY OF BALTIMORE D-45576

D45576

CERTIFICATE OF DEATH.

REGISTERED No. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 N. Mount ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jerome Briant

(Residence in Baltimore: No. 1530 N. Mount St.; 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	Colored	Infant

6-DATE OF BIRTH. Aug. 9, 1919. (Month) (Day) (Year)

7-AGE. 1 yrs. mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Infant
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Jerome Briant

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Susan Harvey

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susan Harvey

(Address) 1530 N. Mount St.

15-

Filed AUG 10 1920 191 Registrar. C. H. Grace

CAUSE OF DEATH to be plainly written, and all questions answered so far as important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 9, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 7 1920, to Aug 9 1920, that I saw him alive on Aug 9 1920, and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. L. McCosh M. D.

Aug. 9, 1920 (Address) 910 N. Stricker St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	Aug. 10, 1920.
20-UNDERTAKER	ADDRESS
Edw. Sprigg & Co	1463 Pennsylvania Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45577 ✓ 28 D45577

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.. 22 WARD)

2-FULL NAME James Smith

(a) RESIDENCE. No. 717 S. Fremont Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Foundry

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Rhode Island

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth McCabe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed SEP 8 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9 1920

17 I HEREBY CERTIFY, That I attended deceased from November 8, 1919, to Aug. 9, 1920, that I last saw him alive on Aug. 8, 1920, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 3 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum; X-ray

(Signed) L. J. Rigney, M. D.

8-9-20. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug 10 1920
20 UNDERTAKER	ADDRESS
Lew Leinbach & Son	647 W Pratt

Spec.—6-9-19—H. P. Co.—1000 Bks.

142504
D45578

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45578

X 45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 72 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E. Wilson Sr.

(a) RESIDENCE. No. 302 S Tryon St. Charlotte North Carolina WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ann Bessie W Wilson

6 DATE OF BIRTH (month, day, and year) Apr. 19 - 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 042

(b) General nature of industry, business, or establishment in which employed (or employer) Lawyer and Banker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Joseph H. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mary E. Phifer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant J. H. Woods
(Address)

15 Filed SEP 8 - 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk

CAUSE OF DEATH MUST BE FILLED IN BY PHYSICIAN IN ALL CASES. See other side for additional information. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1920, to Aug. 10, 1920, that I last saw h[illegible] alive on Aug 10, 1920, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with Terminal uraemia.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Prostate

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? N. C.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm S. Tillett, M. D.

8/10/2019 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charlotte NC	Aug 10 1920
20 UNDERTAKER John O. Mitchell	ADDRESS 1201 W Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 2513 D 45579

HEALTH DEPARTMENT ✠ CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 45579

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Ludinski.

(a) RESIDENCE. No. % Frank Nelka Waterbury ST., Anne Arundel Co. Md. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 29. 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child (10)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Ludinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Frances Nelka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) J. H. Hospital

15 Filed ....., 19 .....

AUG 10 1920 Registrar G. H. Grese

CAUSE OF DEATH in plain terms, so that it may be readily understood. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5. 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 6, 1920, to Aug 5, 1920, that I last saw h[illegible] alive on Aug 5, 1920, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Septicemia (Type undetermined)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Patient home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Autopsy

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Aug 11 1920

20 UNDERTAKER Stephen J. Kiaikowski

ADDRESS 1000 Hanover Corner

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 V

45580

CERTIFICATE OF DEATH.

REGISTERED NO. 45580

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 Richwood Avenue St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Downey

(a) RESIDENCE. No. 519 Richwood Avenue St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 9, 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 600

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Leo Joseph Downey

11 BIRTHPLACE OF FATHER (city or town) Baltimore,
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice Harrison

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Maryland

14 Informant Leo J. Downey
(Address) 519 Richwood Avenue

15 Filed AUG 10 1920 Robert P. Harrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug-9- 1920, to Aug 10 1920, that I last saw h[illegible] alive on Aug 9 1920, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth 6-7 months
Cause unknown

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. O. Hees M. D.

8-10- 1920 (Address) 5600 York Rd Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	8/10 1920
20 UNDERTAKER	ADDRESS
Henry W. Hears & Son	805 N. Calvert

CAUSE OF DEATH must be plainly stated. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

45581 99✓

CERTIFICATE OF DEATH.

REGISTERED NO. 45581

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. East Brooklyn Hgts ST.: 25 WARD)

2-FULL NAME Edward Bausch

(a) RESIDENCE. NO. Elmoody Heights Balto. Md. ST. WARD. 25
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Wh	✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Dec 18 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Pete Bausch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Genevieve Stefkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Pete Bausch Father.
(Address) E. Brooklyn Ave.

15 Filed AUG 10 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1920

17 I HEREBY CERTIFY, That I attended deceased from 8/8/20 . 19 . to 8/10/20 . 19 . that I last saw him alive on 8/10/20 . 19 . and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Thrush

3 Wks.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) R. Johnson M. D.

. 19 (Address) Brooklyn Bank Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	Aug 11 1920

20 UNDERTAKER M. F. Sadowski ADDRESS 705 S. Ann

CAUSE OF DEATH in plain terms, so that it may be classified. Do not use abbreviations or terms of doubtful meaning. Do not report mode of dying, such as heart failure, asphyxia, exhaustion, etc., but the disease or injury which caused it. Fill in all blanks. Use additional sheet if necessary. Information required by law. Failure to comply with the law is punishable by fine. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45582 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45582

CERTIFICATE OF DEATH.

170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28 WARD)

2-FULL NAME Anna McLaughlin (or M. Elma)

(a) RESIDENCE. No. Mt Hope Retreat ST.. 28 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	78	3	8	

8 OCCUPATION OF DECEASED 065

(a) Trade, profession or particular kind of work Sister of Charity -

(b) General nature of industry, business, or establishment in which employed (or employer) Religious work & Nursing -

(c) Name of employer Mt Hope Retreat -

9 BIRTHPLACE (city or town) (State or country) Phila Pa

PARENTS

10 NAME OF FATHER John McLaughlin -

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Harkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna -

14 Informant Records of Mt Hope Retreat

(Address) Mt Hope Balto Md

Filed AUG 10 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 6th, 1920, to Aug 9th, 1920, that I last saw her alive on Aug 9th, 1920, and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Chr - Nephritis -

abt (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Phila Pa -

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Aug 9, 1920 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Hope Cemetery	Aug 11 1920
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45583 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45583

CERTIFICATE OF DEATH.

45V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 S East Ave ST.; 1 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Gross

(Residence in Baltimore: No. 1126 S East Ave St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, ... (Month) ..... (Day) 1870 (Year)

7-AGE About 50 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr H. Burns

(Address) 1126 S East Ave

15- Robert P. Harrison,

(Date) ....., 191..... Registrar.

AUG 10 1920 Burial Permit Clerk

Cause of Death must be given in full and must be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 8th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 28th 1920, to Aug 8th 1920, that I saw him alive on August 7th 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cancer of Bladder

(Duration) ..... yrs. 4 mos. 12 ds.

CONTRIBUTORY (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. W. Jones M. D.

Aug 9th, 1920. (Address) 1013 E. Ellwood ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel	Aug 11, 1920
20-UNDERTAKER Peter Nicolaus	ADDRESS 2041 Eastern

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45584 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45584

CERTIFICATE OF DEATH. 138

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Brogado

(a) RESIDENCE. No. 418 Forrest St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs 19 mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Vincent Brogado

6 DATE OF BIRTH (month, day, and year): Aug. 9th 1899

7 AGE: Years 21 Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Salvatore Tamisella

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Rosina Tamisella

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: University Hospital Records.
(Address)

15 Filed: Aug 12 1920 Robert P. Harrison, Registrar

AUG 10 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-9 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 4 1920 to Aug 9 1920 that I last saw h[illegible] alive on Monday Aug 9, 1920, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Eclampsia (Para 1)

(duration) yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/5/20

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. R. Goldsborough M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Aug 12 1920

20 UNDERTAKER: George J. Reuth

ADDRESS: 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that a ... TION is very important. See instructions on ba...

20.45585 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.45585

CERTIFICATE OF DEATH. REGISTERED No. C 174

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. Mercy Hospital ST.: WARD)

2-FULL NAME John K Hauser. (If not over one year, S. 10 yrs., mos. ds.)

(Residence in Baltimore: No. 2422-E Fleet

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb. 25, 1884.
(Month) (Day) (Year)

7-AGE, 36 yrs. 6 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Truck Driver
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE. (State or Country), Russia

PARENTS.

10-NAME OF FATHER, John K Hauser

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. J. Roth

(Address) 1735 Hanford ave

Filed Aug 10 1920 Robert P Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 9 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

*CAUSE OF DEATH was as follows:

Fractur Skull Accident (Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion (Duration) yrs. mos. 1 ds.

(Signed) G. C. Blady M. D.
(Coroner)
8/10/1920 (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemtery. DATE OF BURIAL, Aug 11, 1920

20-UNDERTAKER Geo. J. Roth ADDRESS 1735 Hanford

N. B.—Every item of information must be given in plain terms, so that it may be properly classified. Exact CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. important.

Spec.—8-24-14—M. & T.—2000 Blks.

D.45586 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45586

CERTIFICATE OF DEATH.

91N

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 N. Exeter St ST.; 5 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence White

(Residence in Baltimore: No. 519 N. Exeter St St. 40 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 4 (Day), 1880 (Year)

7-AGE, 40 yrs. 1 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Joseph Lucky

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Lottie Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Eastern Shore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lottie Lucky

(Address) 519 N. Exeter St

15- AUG 10 1920 Robert P Harrison,

Filed ....., 191.. Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 8 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 4 1920, to Aug 8 1920, that I saw her alive on Aug 7 1920, and that death occurred, on the date stated above, at 7½ p. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ....yrs. 7 mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. 7 mos. ....ds.

(Signed) Luigi D. DiStefano M. D.

Aug 9, 1920 (Address) 407 N. Exeter St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem't

DATE OF BURIAL, Aug. 11, 1920.

20-UNDERTAKER Eb Cook

ADDRESS 502 E North Ave

CAUSE OF DEATH. Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45587 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 45587

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 229 Scott St. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel Gabriel Norfolk

(a) RESIDENCE. NO. 229 Scott St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Dec. 28, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 400

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Chas W Norfolk.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Fox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Chas W Norfolk 229 Scott St

15 Filed AUG 10 1920 Robert P. Harrison, Registrar (Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-10 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 8. 1920, to Aug 10, 1920, that I last saw h[illegible] alive on Aug 9 1920, and that death occurred, on the date stated above, at 445 A M.

The CAUSE OF DEATH* was as follows:

Cholera infantum

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 8 mos. 18 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? Clinical

(Signed) W. G. Bridinger, M. D.

8/10 1920 (Address) 642 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Woodlawn Aug 11 1920

20 UNDERTAKER — ADDRESS

W. Cockey & Sons Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

D45588

HEALTH DEPARTMENT—CITY OF BALTIMORE

15V45588

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Helen Tate St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME 512 N. Stockton St

(Residence in Baltimore: No. 512 N. Stockton St.; ....yrs., 6 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. March 6, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER. Wm Edmond Tate

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER. Sarah Tate

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Tate

(Address) 512 N Stockton St

15-

Filed AUG 11 1920 191.... G. H. Gress Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 10, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 5 1920, to Aug 10 1920, that I saw h[illegible] alive on Aug 9 1920, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Malnutrition from
Lack of proper Care

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. Hudson M. D.

Aug 10 1920 (Address) 117 N Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Bal

DATE OF BURIAL. Aug 11 1920

20-UNDERTAKER Daniel Easton

ADDRESS 916 Eutaw

CAUSE OF DEATH. Be particular and specific. Do not use indefinite terms. Name disease causing death, or in deaths from violent causes, state (1) means of injury; and (2) whether accidental, suicidal, or homicidal. See instructions on back of certificate.

Spec.—8-9-19—H. P. Co.—1000 Bks.

Δ45589 HEALTH DEPARTMENT—CITY OF BALTIMORE 28 Δ45589

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 351 Yale ave ST.; 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Belle Preston

(a) RESIDENCE. NO. 351 Yale ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced (or) WIFE of Bernard Preston

6 DATE OF BIRTH (month, day, and year) July 11-1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Canton Pa

PARENTS

10 NAME OF FATHER John W. Ronan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Troy Pa

12 MAIDEN NAME OF MOTHER Catherine Boland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Elmira N.Y.

14 Informant (Address) Mrs. Catherine Ronan 351 Yale ave

AUG 14 1920

15 Filed ....., 19.... G. H. Gross Registrar

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 8 1920

17 I HEREBY CERTIFY, That I attended deceased from May 27, 19 20, to Aug 8, 19 20, that I last saw h alive on Aug 8, 19 20, and that death occurred, on the date stated above, at 5.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Miliary (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dr not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Et. Autumn

(Signed) Thos Dulany Thomas M. D.

Aug 9, 1920 (Address) 3311 Clark st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	aug 11 1920
20 UNDERTAKER M. J. Hynes	ADDRESS 1432 Light

Spec.—6-9-19—H. P. Co.—1000 Bks.

No number. D45590

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D45590

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Watson.

(a) RESIDENCE. NO. 422 Broad St. Baltimore Md. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Fifty mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 4-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 100

(b) General nature of Industry, business, or establishment in which employed (or employer) Child

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Maggie Fowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J. H. Reeds

(Address)

15 Filed AUG 11 1920 G. H. Greco Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9. 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1920, to Aug 9, 1920, that I last saw h[illegible] alive on Aug 9, 1920, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-intestinal indigestion

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harold L. Higgins, M. D.

8/9, 1920 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arbut. Cemetery	Aug 11 1920
20 UNDERTAKER Mrs Robert F Elliott	ADDRESS 723 Ashland Ave

CAUSE OF DEATH. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-45591

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-45591

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 W. Lorst St. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helda Lyons

(a) RESIDENCE. No. 532 W. Lorst ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 21 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm. Lyons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Estella Taliaferro

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Estella Lyons

(Address) 532 W West St

15 Filed AUG 11 1920

G. H. Creel Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Aug 10 1920

that I last saw her alive on Aug 9 1920

and that death occurred, on the date stated above, at 9.35 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? 532 W. Lorst

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) A. H. Simms M. D.

19 (Address) 714 S. Stanph St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Ct

DATE OF BURIAL Aug 11- 1920

20 UNDERTAKER A. L. Brown & Son

ADDRESS 1018 N. Monto St

CAUSE OF DEATH to be plainly written, so that it can be understood by any person reading it. Abbreviations should not be used. Read carefully the instructions on back of certificates. ATION is very important. See instructions on back.

Spec.—8-24-14—M. & T.—2000 Bks.

845592

HEALTH DEPARTMENT—CITY OF BALTIMORE

845592

CERTIFICATE OF DEATH.

1515

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mary M. Brooks ST.: 22 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME 112 W. Montgomery St.

(Residence in Baltimore: No. Mary M. Brooks St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored.	

6-DATE OF BIRTH, June (Month) 15 (Day), 1920 (Year)

7-AGE, ...yrs. 2 mos. X ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, David Brooks

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Elvira Harmon

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elvira Brooks (mother)

(Address) 112 W. Montgomery St.

15- AUG 11 1920 Filed....., 191.....C. H. Grese Registrar.

Cross out words not important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ~~Aug.~~ Aug. 10 (Month) 10 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ~~Aug.~~ 8 1920, to Aug. 10 1920, that I saw ~~her~~ alive on Aug. 10, 1920, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Primary— Malnutrition

Contributory— Exhaustion

(Duration) ....yrs. ....mos. 20 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. 10 ds.

(Signed) J. P. Young M. D.

8-10-1920 (Address) 506 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Ct	Aug 12, 1920

20-UNDERTAKER	ADDRESS
S. H. Brown & Son	508 W. Monty. St

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45593

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45593

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 146 W Cross ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Barrett.

(a) RESIDENCE. NO. 146 W Cross ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 20th 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Thos Barrett.

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Justina Roth

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Thomas E. Barrett
(Address) 146 W Cross st

15 Filed AUG 11 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10, 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 5, 1920, to Aug 10, 1920, that I last saw h alive on Aug 10, 1920, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute articular Rheumatism (duration) 3 yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. L. Luhrsberg, M. D.

8/10/1920 (Address) 2224 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Aug 12 1920
20 UNDERTAKER	ADDRESS 1529
E. Steltzman & Son	Pennsylvania

CAUSE OF DEATH in plain terms. Indefinite terms, such as "Heart Failure," "Pneumonia," "Cancer," "Tuberculosis," "Paralysis," "Convulsions," "Old Age," "Infantile Debility," "Premature Birth," "Childbirth," "Accident," "Fracture," "Drowning," "Burns," "Shock," "Hemorrhage," "Suicide," "Homicide," "Septicemia," "Blood Poisoning," "Uremia," "Abscess," "Debility," "Senility," "Marasmus," "Malnutrition," "Exhaustion," "Coma," "Asphyxia," "Meningitis," "Peritonitis," "Nephritis," "Hepatitis," "Gastritis," "Enteritis," "Colitis," "Appendicitis," "Hernia," "Obstruction," "Ulceration," "Perforation," "Rupture," "Embolism," "Thrombosis," "Aneurism," "Arteriosclerosis," "Cirrhosis," "Degeneration," "Dropsy," "Edema," "Anemia," "Leukemia," "Pyemia," "Toxemia," "Intoxication," "Infection," "Inflammation," "Ulcer," "Tumor," "Growth," "Mass," "Lump," "Swelling," "Pain," "Fever," "Chill," "Sweat," "Cramp," "Spasm," "Tremor," "Weakness," "Numbness," "Dizziness," "Headache," "Backache," "Stomachache," "Toothache," "Earache," "Sore Throat," "Cough," "Cold," "Grippe," "Influenza," "Malaria," "Typhoid," "Typhus," "Scarlet Fever," "Measles," "Whooping Cough," "Mumps," "Chicken Pox," "Smallpox," "Diphtheria," "Tetanus," "Rabies," "Syphilis," "Gonorrhea," "Chancroid," "Granuloma," "Lymphogranuloma," "Trachoma," "Conjunctivitis," "Otitis," "Mastoiditis," "Sinusitis," "Rhinitis," "Laryngitis," "Bronchitis," "Pleurisy," "Empyema," "Abscess," "Gangrene," "Necrosis," "Caries," "Osteomyelitis," "Arthritis," "Rheumatism," "Neuritis," "Neuralgia," "Sciatica," "Lumbago," "Myalgia," "Fibrositis," "Bursitis," "Tenosynovitis," "Dermatitis," "Eczema," "Psoriasis," "Pemphigus," "Erysipelas," "Cellulitis," "Phlegmon," "Furuncle," "Carbuncle," "Boil," "Pustule," "Vesicle," "Bulla," "Rash," "Eruption," "Exanthem," "Enanthem," "Petechiae," "Purpura," "Ecchymosis," "Hematoma," "Contusion," "Laceration," "Wound," "Incision," "Puncture," "Amputation," "Dislocation," "Sprain," "Strain," "Concussion," "Compression," "Asphyxiation," "Suffocation," "Strangulation," "Drowning," "Electrocution," "Poisoning," "Overdose," "Addiction," "Withdrawal," "Delirium," "Hallucination," "Insanity," "Psychosis," "Neurosis," "Epilepsy," "Convulsions," "Coma," "Stupor," "Syncope," "Collapse," "Shock," "Hemorrhage," "Thrombosis," "Embolism," "Infarction

Spec.—6-9-19—H. P. Co.—1000 Bks.

1945594 HEALTH DEPARTMENT—CITY OF BALTIMORE 1945594

CERTIFICATE OF DEATH. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1246 Sargeant St ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalie Klemsteni

(a) RESIDENCE. No. 1246 Sargeant ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Otto V. Klemsteni

6 DATE OF BIRTH (month, day, and year) Feby 18-1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Richard Dontag

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dort Knott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Otto V. Klemsteni

(Address) 1246 Sargeant St

AUG 11 1920 ROBERT E. LEADER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1920

17

I HEREBY CERTIFY, That I attended deceased from June 2 1920, to Aug 9 1920, that I last saw her alive on Aug 9 1920, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd, M. D.

8-11 1920 (Address) 612 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	Aug 12 1920
20 UNDERTAKER	ADDRESS
J. Herwig & Co	1008 Gilmor

CAUSE OF DEATH must be given in plain English. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

045595 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓045595

172

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Maple Ave near Belmont ST.: Boyd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Weber

(a) RESIDENCE. No. Maple Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo B Weber

6 DATE OF BIRTH (month, day, and year) Mar 6-1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jacob Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie M Dahl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma C Jurgens

(Address) Maple Ave near Belmont Rd

15 Filed AUG 11 1920 ROBERT E LEACH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 - 1920

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1920, to August 9, 1920

that I last saw her alive on August 8, 1920

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Acute Dilatation of the Heart

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Fracture right femur and left forearm.

(duration) yrs. 1 mos. 18 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert G Webster M.D. M. D.

, 19 (Address) Belmont ave Belmont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Aug 11 1920
20 UNDERTAKER J Herweg & Co	ADDRESS 2008 Mcam

CAUSE OF DEATH to plain terms, ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D45596

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45596

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 Ashburton St.; 15th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Emmerich

(Residence in Baltimore: No. 1819 Ashburton St.; ....yrs.,....mos.....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, June (Month) 14th (Day), 1866 (Year)

7-AGE, 54 yrs. 1 mos. 25 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Motion Picture Theatre Prop 886

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 5 months

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Ludwig Emmerich

11-BIRTHPLACE OF FATHER (State or Country). Hesse Darmstadt Ger

12-MAIDEN NAME OF MOTHER. Lizetta Broening

13-BIRTHPLACE OF MOTHER (State or Country). Hesse Darmstadt Ger

14-THE ABOVE IS ~~TRUE~~ TO THE BEST OF MY KNOWLEDGE.

(Informant) Ged Emmerich

(Address) 1413 St Charles St.

15- AUG 11 1920 ROBERT I. HUNTER

Filed....., 191.... DEPUTY REGISTRAR Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 8 (Day), 1920 (Year)

I HEREBY CERTIFY, That I attended deceased from July 26th 1920, to Aug 8th 1920, that I saw h.. alive on Aug 8th 1920, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) ....yrs. ....mos. 7 da.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) 6 yrs. ....mos. ....da.

(Signed) J. C. Poulton M. D.

Aug 9th, 1920 (Address) 65 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Aug 11th, 1920

20-UNDERTAKER George J. Kuhl

ADDRESS 1735 Harford Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

245597 245597 10-119

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 Peach alley ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nancy Hayman

(Residence in Baltimore: No. 118 Peach alley St.; 10 yrs. ..... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, Feb. (Month) 12 (Day) 1902 (Year)

7-AGE, 18 yrs. 5 mos. 27 da. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waitress
(b) General nature of industry, business, or establishment in which employed (or employer): Private Family

9-BIRTHPLACE, (State or Country): Annapolis Md

PARENTS.

10-NAME OF FATHER, William Hayman

11-BIRTHPLACE OF FATHER (State or Country), Eastern Shore Md

12-MAIDEN NAME OF MOTHER Mary Evans

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wesley Hayman Brother

(Address) 118 Peach alley

15- AUG 11 1920 [illegible] 191.....

Filed ....., 191..... [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 7, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 23 1920, to August 9 1920, that I saw h[illegible] alive on August 9 1920, and that death occurred, on the date stated above, at 3:00 p. m.

The CAUSE OF DEATH* was as follows:

Enteric Perforation

Acute Peritonitis

Influenza

(Duration) ..... yrs. 1 mos. 16 da.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) ..... yrs. 2 mos. 15 da.

(Signed) D. F. Shelton M. D.

(Address) 20 W. Pleasant Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, [illegible] Annapolis

DATE OF BURIAL, Aug 11, 1920

20-UNDERTAKER R. L. Parham

ADDRESS 649 W. Lee St.

N. B.—Every item of information should be carefully considered, that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45598 HEALTH DEPARTMENT—CITY OF BALTIMORE D45598

CERTIFICATE OF DEATH.

REGISTERED NO. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1821 E. Pratt. St ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene V. Wesniewski

(a) RESIDENCE. NO 1821 E. Pratt ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Wht

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of Industry, business, or establishment in which employed (or employer) None.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wladyslaw Wesniewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Felicia Bronzet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant W. Wesniewski

(Address) 1821 E. Pratt.

15 Filed AUG 11 1920 ROBERT P. BRUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 6 1920, to Aug 10 1920, that I last saw h alive on Aug 9 1920, and that death occurred, on the date stated above, at 9 m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2718 Fleet St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam.

(Signed) A T Kiss, M. D.

Aug 10 1920 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary.	Aug 11 1920
UNDERTAKER	ADDRESS
Wm Falkowski	168 Eastern Ave

TION is very important. See instructions on back of certificate.

D 45599 HEALTH DEPARTMENT--CITY OF BALTIMORE D 45599

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C 89

CITY OF BALTIMORE (No. 15 E. 21st St. 12 Ward)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard M. Bowerman

(Residence in Baltimore: No. 15 E. 21st St.; 89 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: May (Month) 12 (Day), 1831 (Year)

7 AGE: 89 yrs. 2 mos. 27 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired, Book keeper
(b) General nature of industry, business, or establishment in which employed (or employer): Gas & Electric Co

9 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Henry Bowerman

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Biays

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Nancy Bowerman

(Address) 15 E 21st St

15 Filed AUG 11 1920 191 ROBERT E LEAUTER REGISTRAR

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug (Month) 9th (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3rd, 1920, to. Aug 9th 1920, that I saw him alive on Aug 9th, 1920, and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:

General debility

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Bronchitis

(Duration) ..... yrs. ..... mos. 8 ds.

(Signed) C. V. Valentine M. D.

Aug 9th, 1920 (Address) 2413 St Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Greenmount Cem. DATE OF BURIAL: Aug 11 1920

20 UNDERTAKER: John C. Mitchell ADDRESS: 1301 W. Fayette

N. B.—Every item of information should be carefully supplied. Read instructions on back of certificate. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D45600

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45600

CERTIFICATE OF DEATH.

147

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 N Payson ST.; 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edwin Gorman Nickerson

(Residence in Baltimore: No. 921 N. Payson St.; 4 yrs., 5 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Mar (Month) 4 (Day), 1916 (Year)

7-AGE, 4 yrs. 5 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Child

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Arthur G Nickerson

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Augusta Helmke Shue.

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur G Nickerson

(Address) 921 N Payson

15-

Filed AUG 11 1920, 191.... C. H. Cress. Registrar.

AUG 11 1920 C H C

CAUSE OF DEATH. Write plainly and use no abbreviations. Give the disease causing death, directly and primarily, as well as any antecedent causes. Morbid conditions, if any, giving rise to the above cause, should be stated. It is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 10 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29 1920, to Aug 10 1920, that I saw h-e alive on Aug 10 1920, and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Status Endocarditis

(Duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Multiple Septic Infarcts

(Duration) ... yrs. ... mos. 18 ds.

(Signed) Thos. A Schaefer M. D.

Aug 10, 1920 (Address) 2505 W Balto Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Bcm

DATE OF BURIAL, Aug 12, 1920

20-UNDERTAKER W M Rountree

ADDRESS 230 N Eutaw

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045601

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045601

CERTIFICATE OF DEATH.

REGISTERED NO. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 Smith ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Webster

(a) RESIDENCE. NO. 1407 Smith ST.: 16 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 29- 20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John H. Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Rosie Webster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant John H. Webster

(Address) 1407 Smith St.

15 Filed AUG 11 1920 ROBERT F. FLAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1920, to Aug 10, 1920, that I last saw him alive on Aug 10, 1920, and that death occurred, on the date stated above, at 10 15 A. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) — yrs. 4 mos. 11 ds.

CONTRIBUTORY (Secondary) Infantile Convulsions

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Balto, Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) James Edw. Bell, M. D.

, 19 (Address) 1506 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters

DATE OF BURIAL Aug 11 1920

20 UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain words. ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D45602 D45602 D45602

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. S.W. Fulton Ave and Franklin ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Elizabeth Locke

(Residence in Baltimore: No. Home for the Aged of the M.E. Church St.; 5yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct (Month) 26 (Day), 1836 (Year)

7-AGE, ~~83~~ 83 yrs. 9 mos. 13 days. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm. Beaver.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Mary Ann Reese

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Gundry

(Address) 400 Fulton Ave

15- Filed AUG 11 1920, 191... ROBERT F. BRAUER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 10 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1920, to Aug 10 1920; that I saw her alive on Aug. 7 1920; and that death occurred, on the date stated above, at 9p m.

The CAUSE OF DEATH* was as follows:

Toxaemia due to Hypertension, and Fibroid together with her age (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis. (Duration) 2 yrs. ✓ mos. ✓ ds.

(Signed) Geo. C. Shannon M. D.

Aug 11, 1920 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 10 yrs. ... mos. ... ds. In the State 83 yrs. 9 mos. 13 ds.

Where was disease contracted, if not at place of death? at the Home

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Mount Cemetery — DATE OF BURIAL, Aug 13, 1920

20-UNDERTAKER Geo J Smith — ADDRESS Fayette

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

045603 HEALTH DEPARTMENT—CITY OF BALTIMORE 045603.

CERTIFICATE OF DEATH.

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1921 Regester ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy L. McFarland.

(Residence in Baltimore: No. 1920 Regester St St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, March 26, 1920
(Month) (Day) (Year)

7-AGE, ... yrs. 4 mos. 15 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Baby
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, John McFarland.

11-BIRTHPLACE OF FATHER (State or Country) Balto

12-MAIDEN NAME OF MOTHER Ida Williams

13-BIRTHPLACE OF MOTHER (State or Country) Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida McFarland

(Address) 1921 N. Regester St

15-

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 10, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 9 1920, to Aug 10 1920, that I saw her alive on Aug 10 — 1920, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

..... Ileo-Colitis .....

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. Gill Hall M. D.

Aug 10, 1920 (Address) 1617 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Aug 13, 1920

20-UNDERTAKER E. A. Needham | ADDRESS 2 Green Mt Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

142246. L 045604 — 1045604

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. St.) 9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine F Wirtz

(a) RESIDENCE. No. 546 Carswell St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) 800

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER John P. Surney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Catherine Wirtz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant J. H. Brands

(Address)

AUG 11 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1920

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1920, to Aug 10, 1920, that I last saw h. alive on Aug 10, 1920 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery.

(duration) yrs. mos. 26 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Stool culture

(Signed) Harold L. Skaggs M. D.

8/10, 1920 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	8/12 1920
20 UNDERTAKER J. G. Moran	ADDRESS 3000 E. Baltimore

CAUSE OF DEATH in plain terms. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45605

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D45605

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elijah Darling

(a) RESIDENCE. NO. 30 S. Carolina St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West Indies

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records,
(Address): New City Hospital.

15 Filed AUG 11 1920 G. H. Greer Registrar

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 7, 1920

17

I HEREBY CERTIFY, That I attended deceased from April 15, 1920, to August 7, 1920, that I last saw him alive on August 7, 1920, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis (No cerebral hemorrhage)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) [illegible], M. D.

8/9/1920 (Address) New City Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Aug 11 1920
20 UNDERTAKER	ADDRESS
Charles B. Jones	820 Lanvale St

D45606 HEALTH DEPARTMENT—CITY OF BALTIMORE D45606

CERTIFICATE OF DEATH.

REGISTERED No. C. 150

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1513 Pennsylvania Ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith Rebecca Robinson

(Residence in Baltimore: No. 1513 Pennsylvania ave St.; yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
female	black	single

6-DATE OF BIRTH, July 13, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none (infant)
(b) General nature of industry, business, or establishment in which employed (or employer). none

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER. Charles Henry

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Sarah Robinson

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ~~Sarah~~ Sarah Robinson

(Address) 1513 Pennsylvania Ave

15-

Filed AUG 11 1920 ..... Registrar.

CAUSE OF DEATH to plain terms, so that it may be understood. Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. August 10, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tetanus from burn

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Aug. 10, 1920 (Address) 2802 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Ag

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cemetery	Aug 14, 1920
20-UNDERTAKER Mitchell Easton	ADDRESS 825 Lanvale St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45607 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45607

CERTIFICATE OF DEATH.

28

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1749 Hanover ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Sadler

(a) RESIDENCE. No. 1749 Hanover ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	Sept.	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House painter

(b) General nature of industry, business, or establishment in which employed (or employer) 050

(c) Name of employer Lorenz Lucker

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Henry Sadler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Caroline Whitely

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Charles Thomas Sadler
(Address) 1749 Hanover St

15 Filed AUG 11 1920 19 G. H. Gre... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11, 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 7, 1920, to Aug 11, 1920, that I last saw h... alive on Aug 10, 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Schwartzman, M. D.

8/11, 1920 (Address) 1 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	aug 13 1920

20 UNDERTAKER William Cook ADDRESS 502 E North ave

CAUSE OF DEATH must be given. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

Michael Ratajczak

1045608

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045608

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1615 Fleet (St.; or) 7 (Ward)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Ratajczak

(Residence in Baltimore: No. 160 Fleet st St.; 8 yrs., 3 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, July 9, 1912
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
8 yrs. 3 mos. 3 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... DOD
(b) General nature of industry, business, or establishment in which employed (or employer)..... School Boy

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Ratajczak.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore. Md.

12-MAIDEN NAME OF MOTHER Mary Micholak

13-BIRTHPLACE OF MOTHER (State or Country), Poland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Ratajczak.

(Address) 1615 Fleet St

15- AUG 11 1920 ROBERT P. FRAZIER

Filed....., 191.. Registrar.

CAUSE OF DEATH. Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 11, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 7 1920, to Aug 11 1920,
that I saw h— alive on Aug 11 1920,
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Probably Measles

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. Wiemann M. D.

Aug 11, 1920 (Address) 165 Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus	Aug. 12, 1920

20-UNDERTAKER W. F. Sudowski

ADDRESS 605 S. Ann

Spec.—8-24-14—M. & T.—2000 Bks.

D45609 HEALTH DEPARTMENT—CITY OF BALTIMORE D45609

64

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 544 W. Preston ST.; 17 WARD.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cecelia Adams

(Residence in Baltimore: No. 544 W Preston St.; 74 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Widow

6-DATE OF BIRTH, ... — (Month) — (Day), 1846 (Year)

7-AGE, 74 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... —

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mollie Scott

(Address) 546 W. Preston St.

15- Filed AUG 11 1920 G. H. G[illegible] Registrar.

CAUSE OF DEATH to be plainly written. Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 9th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 9th 1920, to Aug 9th 1920, that I saw her alive on Aug 9th 1920, and that death occurred, on the date stated above, at 7.20 p m.

The CAUSE OF DEATH* was as follows:

1. .....
2. .....
3. .....

Cerebral Hemorrhage (Duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Hemiplegia (Duration) 2 yrs. — mos. — ds.

(Signed) Edward Lee Thomas M. D.

Aug 11th, 1920. (Address) 320 W. Martin Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cem	Aug 11, 1920.
20-UNDERTAKER Frank Stansbury	ADDRESS 578 W Baltimore

D45610 HEALTH DEPARTMENT—CITY OF BALTIMORE D45610

150

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 558 W. Preston St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Leonard

(Residence in Baltimore: No. 558 W. Preston St. St.: yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	Black	Single

6-DATE OF BIRTH, August 9, 1920
(Month) (Day) (Year)

7-AGE, ...yrs.....mos.....ds.

If LESS than 1 day, 8 hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none (Infant)
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Emory P. Leonard

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Laura Burke

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence B. Burke

(Address) 558 W. Preston St.

15- Filed AUG 11 1920, 191..... C. H. Grese. Registrar.

CAUSE OF DEATH to be plainly written. Every question must be answered if important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 9, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Obstruction Pharynx Dr by

(Duration).....yrs.....mos....1....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

August 10, 1920 (Address) 2502 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Aug 12 1920

20-UNDERTAKER Samuel L. Hemsley ADDRESS 5818 Belair Rd

Spec.—8-24-14—M. & T.—2000 Bks.

Harriet Preston

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45611 D45611

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 Dondstill Ave St.; 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harriet Preston

(Residence in Baltimore: No. 1124 Dondstill Ave St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown, 1865
(Month) (Day) (Year)

7-AGE, 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9-BIRTHPLACE, (State or Country), Calvert Co. Md

PARENTS.

10-NAME OF FATHER. Butler Ennis

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Kitty Ennis

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizah Preston

(Address) 1109 Latrobe St

15-

Filed AUG 11 1920, 191.. G. H. Grese. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Monday Aug 9th, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from April 11th 1920, to Aug 9th 1920, that I saw h r alive on Aug 8th 1920, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Val. Dis of Heart
(Mitral)

(Duration) 4 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. ds.

(Signed) E Stanley M. D.

Aug 11th, 1920 (Address) 609 E. Lombard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Aug 12 1920

20-UNDERTAKER, Samuel Kennedy

ADDRESS, 1516 N Eutaw St

CAUSE OF DEATH must be given. See instructions on back of certificate.

D 45612 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45612

CERTIFICATE OF DEATH.

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1417 N. Rose St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hilda. E. Lloyd.

(Residence in Baltimore: No. 1417 N. Rose st

Stay yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, May 7th, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. 2 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——— None.
(b) General nature of industry, business, or establishment in which employed (or employer) ———

9-BIRTHPLACE, (State or Country), Balt. Md

PARENTS.

10-NAME OF FATHER, William Lloyd.

11-BIRTHPLACE OF FATHER (State or Country), Balt. Md.

12-MAIDEN NAME OF MOTHER Grace Lloyd.

13-BIRTHPLACE OF MOTHER (State or Country), Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Lloyd.

(Address) 1417. N. Rose st.

15- AUG 11 1920 G. H. Grist.

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 8 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) ———

(Duration) ...yrs. ...mos. ...ds.

(Signed) J. R. Lyons M. D.
(Coroner)

8-9-20 (Address) 1 E. Lex st.

*State the DISEASE CAUSING DEATH or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery. DATE OF BURIAL, Aug. 11, 1920

20-UNDERTAKER George L. Ruth ADDRESS 735 Hanford

CAUSE OF DEATH in plain terms, so that it may be properly coded. All items important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45613 D 45613 104 D 45613

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 701-S-5th ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marcyzanna Swrontek

(Residence in Baltimore: No. 701 S-5th St. St.; ....yrs. 1 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, ~~MARRIED, WIDOWED,~~ OR ~~DIVORCED.~~ (Write the word.) S

6-DATE OF BIRTH, 7 (Month) 15 (Day), 1920 (Year)

7-AGE, ...yrs. 26 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Swratek

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Mary Jankowski

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph Swratek
(Address) 701 S. Fifth St.

15- AUG 11 1920 Filed....., 191..... G. H. Cress Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 10 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8/10/20 191..., to 8/10/20 191..., that I saw h er alive on 8/10/20 191..., and that death occurred, on the date stated above, at 9.50 p.m.

The CAUSE OF DEATH* was as follows:

Toxaemia

(Duration) ....yrs. ....mos. V ds.

CONTRIBUTORY (Secondary) Ileo Colitis

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. M. Garrell M. D.

(Address) 633-S-3rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus Cem. DATE OF BURIAL, Aug. 12, 1920

20-UNDERTAKER Stephen J. Kaczorowski ADDRESS 1005 S. Hanover

Acc

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45614 HEALTH DEPARTMENT—CITY OF BALTIMORE D45614

CERTIFICATE OF DEATH. X 108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen'l Hosp. ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Franklin Lazenby

(a) RESIDENCE. No. Md. General Hosp. ST., WARD. Ellicott City

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 600

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William A Lazenby

11 BIRTHPLACE OF FATHER (city or town) (State or country) D. Columbia

12 MAIDEN NAME OF MOTHER Mammie Foy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Front Royal Va

14 Informant William A Lazenby

(Address) Ellicott City Md

15 Filed AUG 11 1920 G. H. Cross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 10: 2 PM. 1920. to Aug 10: 1920.

that I last saw him alive on Aug 10, 2 PM 1920.

and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis following
Rupture of Appendix

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at residence

Did an operation precede death? Yes Date of Aug 10, 20

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W. F. Foy Jr Pumpelly M. D.

, 19 (Address) Md General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Johns Cem Howard Co	Aug 13 1920
20 UNDERTAKER Castle & Sons	ADDRESS Ellicott City

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H P. Co.—1000 Blks.

D45615 HEALTH DEPARTMENT—CITY OF BALTIMORE D45615

CERTIFICATE OF DEATH.

4 79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 659 W. Saratoga ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ursula Bernochiute

(a) RESIDENCE. No. 659 W. Saratoga ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
47				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Peter Bernotas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Carolina Kdanait

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant J. Bernotas

(Address) 659 W. Saratoga St.

15 Filed AUG 11 1920 Registrar C. H. Grese.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1920, to Aug. 10, 1920, that I last saw her alive on Aug. 10, 1920, and that death occurred, on the date stated above, at 5:50 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Dis.

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) J. B. Bronusas, M. D

(Address) 615 Columbia Ave. 8-11-1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 12 1920
20 UNDERTAKER	**ADDRESS**
John Gobliauckas	423 S. Pere St.

CAUSE OF DEATH must be given by physician. Please read carefully instructions on back of certificate. INFORMATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45616

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45616

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1831 Kavanaugh ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Mary F Woodem

(Residence in Baltimore: No. 1831 Kavanaugh St.: abt 6 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept 5 1866, 1 (Month) (Day) (Year)

7-AGE, 54 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Loud Co. Va

PARENTS.

10-NAME OF FATHER, John White

11-BIRTHPLACE OF FATHER (State or Country), Loud co Va

12-MAIDEN NAME OF MOTHER Rebree Ramme

13-BIRTHPLACE OF MOTHER (State or Country), Loud co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss M. Worden

(Address) 1831 Kavanagh St.

15- Filed AUG 11 1920, Robert P. Harrison, Registrar.

Burial Permit Clerk.

CAUSE OF DEATH to be plainly written. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 8, 1920 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from March 2 1920, to Aug. 7, 1920, that I saw her alive on Aug. 7, 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John D. Quinn M. D.

Aug. 8, 1920 (Address) 1507 W. Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Aug 11 1920

20-UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

Spec.—6-9-19—H. P. Co.—1000 Bks. Baby Harbaugh, 911 N. Stricker St.

D.45617 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45617

CERTIFICATE OF DEATH. 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 Stricker St. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant child of Dennis Thomas Harbaugh

(a) RESIDENCE. No. 911 N Stricker St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
			7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer —

9 BIRTHPLACE (city or town) 911 N Stricker (State or country) Baltimore

PARENTS

10 NAME OF FATHER Dennis Harbaugh

11 BIRTHPLACE OF FATHER (city or town) Alabama

(State or country)

12 MAIDEN NAME OF MOTHER Theresa Krieger

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Theresa Harbaugh

(Address)

15 Filed Aug 11 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 10, 1920, to Aug 10, 1920, that I last saw he alive on Aug 10 1920, and that death occurred, on the date stated above, at 10 30 p m.

The CAUSE OF DEATH* was as follows: Incomplete closure of Foramen Ovale

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? No

(Signed) C R Davis M.D.

19 (Address) 2109 Mount Field Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Sepulchre	Aug 11 1920

20 UNDERTAKER Geo L Schwab & Bro ADDRESS 5101 Eadle Ave.

AUG 11 1920

CAUSE OF DEATH must be stated by physician. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45618

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45618

104

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Mary White

(Residence in Baltimore: No. St. Elizabeth's Home St.; ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	Col.	

6-DATE OF BIRTH, June (Month) 10 (Day), 1920 (Year)

7-AGE, ...yrs. 1 mos. 28 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Clarence White

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Dorothy White

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Filed AUG 11 1920, 19... Robert P. Garrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 8 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1920, to Aug 6 1920, that I saw h.. alive on Aug 6 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

.....

Atrophia

..... (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary).....

..... (Duration) ...yrs. ...mos. ...ds.

(Signed) Frank J. Ayd M. D.

Aug 9, 1920 (Address) 2005 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ... 191...

20-UNDERTAKER .....

ADDRESS .....

AUG 10 1920

Commissioner of Health.

For city Burial

CROSS OUT WORDS NOT APPLICABLE. See instructions on back of certificate. important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45619 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45619

CERTIFICATE OF DEATH. X 108

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 225 N. Mount St. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Commander

(a) RESIDENCE. NO. 225 N. Mount ST., WARD. Elizabeth City N. C.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. 2 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
29 52	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel P

(c) Name of employer T.B.Harris

9 BIRTHPLACE (city or town) Elizabeth City (State or country) N.C.

PARENTS

10 NAME OF FATHER Hardy Commander

11 BIRTHPLACE OF FATHER (city or town) Elizebeth (State or country) City N.C.

12 MAIDEN NAME OF MOTHER Mahaley Rogers

13 BIRTHPLACE OF MOTHER (city or town) Wilamston (State or country) N.C.

14 Informant Alie White (Address) 225 N. Mount st

15 Filed AUG 11 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/10 1920

17 I HEREBY CERTIFY, That I attended deceased from 8/7/20, 1920, to 8/10/20, 19..., that I last saw him alive on 8/10/20, 19..., and that death occurred, on the date stated above, at 2:40 P. m.

The CAUSE OF DEATH* was as follows:

Acct. Peritonitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acct. Appendicitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Walter C. Jackson, M. D.

, 19 (Address) 1618. W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Aug 12 1920

20 UNDERTAKER A. Jones ADDRESS 209 S Stricker St

CAUSE OF DEATH must be stated plainly. Use no abbreviations. Do not state mode of dying, but the disease, casualty or complication which caused death. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 45620 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 45620

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH Little Sisters of the Poor REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 10 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Carroll

(Residence in Baltimore: No. Bel Air Rd St.; 2 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7-AGE. About 75 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. James Carroll

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER Bridget Hayes

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed AUG 11 1920, 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Aug. 11th (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191.., to ..... 191.., that I saw h.. alive on Aug 11 1920, and that death occurred, on the date stated above, at 4 15 P. m.

The CAUSE OF DEATH* was as follows:

..... Valvular disease of heart

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Dropsy

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) F. A. Warner M. D.

Aug 11, 191.. (Address) 11 33 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Bellair Md	Aug 13 1920
20-UNDERTAKER	ADDRESS
Per James B Hayes	Bellair Md

Spec.—6-9-19—H. P. Co.—1000 Bks.

~~44252~~ D.45621

D.45621

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14-091

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Collins.

(a) RESIDENCE. No. 512 N. Bradford St. Baltimore St.; WARD. Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 25-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): 900

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Albert Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Smith.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) J. H. H. Records

15 Filed AUG 11 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-11 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 7- 1920, to Aug 11, 1920, that I last saw him alive on Aug 11, 1920, and that death occurred, on the date stated above, at 2.50 a. m.

The CAUSE OF DEATH* was as follows:

Dysentery (Flexner)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Patapsco

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stool culture

(Signed) [illegible], M. D.

, 19 (Address) J.H.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 13 1920
20 UNDERTAKER	ADDRESS
Jas. C. Miller	2334 Jeffer...

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—R. P. Co.—1000 Bks.

D.45622

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45622

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (Municipal Tuberculosis Hospital WARD 7)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Mish

(a) RESIDENCE. No. 900 Rutland Ave. ST., WARD.

(Usual place of abode) 5 years

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown 5 years ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Robert Grossel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Madeline Schinder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address) M.T.H.

15 Filed AUG 11 1920 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 9, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1920 to August 9, 1920.

that I last saw her alive on August 9, 1920,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum; X-ray

(Signed) L.J. Rigney, M. D.

8-10-20, 19 (Address) Municipal Tuberculosis Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 12 1920
20 UNDERTAKER	ADDRESS
Jas C. Muller	2334 Jeff St

CAUSE OF DEATH must be filled in by physician. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 45623 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45623

+42499

CERTIFICATE OF DEATH.

104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Baltimore ST.: H.C. WARD)

2-FULL NAME Mildred Russell.

(a) RESIDENCE. No. 32 S Green St. Baltimore Md WARD.

(Usual place of abode)

Length of residence in city or town where death occurred unknown. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 19-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4½		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Loyd Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Esther Fitzhugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Illinois

14 Informant (Address) J. H. Russell.

15 Filed AUG 11 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-10 1920

17 I HEREBY CERTIFY, That I attended deceased from August 5, 1920, to Aug 10, 1920, that I last saw h.r alive on Aug 10, 1920, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Patient Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) Wm Lapp, M. D.

, 19 (Address) 1410

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Aug 12 1920
20 UNDERTAKER	ADDRESS
Jones & Jones	1247 W Fayette St

CAUSE OF DEATH. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45624 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45624

CERTIFICATE OF DEATH. 104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 Longwood ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Schek

(a) RESIDENCE. NO. 503 Longwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles W. Schek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mildred McConkey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) Charles W. Schek. 503 Longwood St.

15 Filed AUG 11 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11- 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 9th, 1920, to Aug 11th, 1920, that I last saw h[illegible] alive on Aug 10, 1920, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Lobar Collapse

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. H. Burbert, M. D.

Aug 11, 1920 (Address) 1100 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Aug 12- 1920
20 UNDERTAKER Wm. Cook	ADDRESS 502 E. Monument

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

.—6-9-19—H. P. Co.—1000 Bks.

45625 HEALTH DEPARTMENT—CITY OF BALTIMORE D45625

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Y OF BALTIMORE: No. Johns Hopkins Hospital WARD)

2-FULL NAME William M. Scruders

(a) RESIDENCE. No. Johns Hopkins Hosp. ST., WARD. Johnstown Pa.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Dora Scruders

DATE OF BIRTH (month, day, and year) 1869

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Loader in Mill

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Lemon Scruders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Harriet Rhoades

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Mrs Dora Scruders
(Address) 122 Conemaugh Johnstown Pa

15 Filed ....., 19.... Registrar

AUG 19 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 19 20, to Aug 11, 1920, that I last saw him alive on Aug 11, 1920, and that death occurred, on the date stated above, at 7 25 p m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

about four
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Operated

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug 11 '20

Was there an autopsy? Yes - Lund city

What test confirmed diagnosis?

(Signed) W C Huntzler, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnstown Pa — DATE OF BURIAL Aug 14 1920

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 N Bway

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45626 × 19 D45626

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles F. Mallory—

(Residence in Baltimore: No. 568 Presstman st St.; ... yrs., 3 mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Aug 13, 1853. (Month) (Day) (Year)

7-AGE, 67 yrs. 11 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work [illegible]
(b) General nature of industry, business, or establishment in which employed (or employer) Barber

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Henry Mallory

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Toomey

(Address) 568 Pustman st

15-

Filed ....., 191.....

AUG 12 1920 C. H. Grise Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 11th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 9th 1920, to Aug 11th 1920, that I saw h[illegible] alive on Aug 11 1920, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation of the Heart

..... (Duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary) not known

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) Harry T. Brown M. D.

Aug 11, 1920 (Address) 560 Presstman st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ... yrs. ... mos. 2 ds. In the State ... yrs. 3 mos. — ds.

Where was disease contracted, if not at place of death? not known

Former or usual residence not known

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemty — DATE OF BURIAL, Aug. 14 1920

20-UNDERTAKER Roger H. Holland — ADDRESS 1631 Eutaw Pl Holland

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45627

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45627

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital ST. ... WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Wm. A. Bosley

(a) RESIDENCE. NO. 119 Warren Avenue WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Wm. Bosley

6 DATE OF BIRTH (month, day, and year) May 8-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61 yrs.	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " " "

12 MAIDEN NAME OF MOTHER " " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " " "

14 Informant Mrs Sam Bosley (Address) same add

15 Filed AUG 12 1920 19 Registrar G. H. Grese

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10, 1920

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1920 to Aug 10, 1920 that I last saw h... alive on Aug 10, 1920 and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Sarcoma
Glands of neck

(duration) ... yrs. 5 mos. ... ds.

CONTRIBUTORY (Secondary) Metastases to Lungs

(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Apr 24

Was there an autopsy? No

What test confirmed diagnosis? Microscopic section

(Signed) Wm. A. Bosley M. D.

. 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Maryland Line Md	Aug 11 1920

20 UNDERTAKER	ADDRESS
Wm J Pickell & Sons	North & Pa

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45628

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45628

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bx Jos. Hosp. St.: 9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Leopold

(a) RESIDENCE. No. Mulberry & Park Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Wh.	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 5th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Baby~~

(b) General nature of industry, business, or establishment in which employed (or employer) Baby

(c) Name of employer Bx Jos. Hosp.

9 BIRTHPLACE (city or town) (State or country) Bx Jos. Hosp. Md.

PARENTS

10 NAME OF FATHER Harry B. Leopold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Florence Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Harry B. Leopold
(Address) Mulberry & Park ave

15 Filed AUG 12 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 5th 1920, to Aug 11th 1920, that I last saw her alive on Aug 11th 1920 and that death occurred, on the date stated above, at 5 55 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph D Herring M. D.

19 (Address) 1825 N Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shirley Memorial Park	Aug 12 1920
20 UNDERTAKER	ADDRESS
W J McKeown	North Ave

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45629 D45629

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2701 Frederick Ave.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hartman A Miller

(Residence in Baltimore: No. 2701 Frederick Ave St.: Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	W'te	Single

6-DATE OF BIRTH, Oct 13, 1861
(Month) (Day) (Year)

7-AGE, 58 yrs. 9 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): Refuge Station

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Hartman Miller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Sophia E Hoyle

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph H. Miller

(Address) 2701 Frederick Ave

15- AUG 12 1920 191.... ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 10, 192.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 27 1920, to Aug 10 1920, that I saw h in alive on Aug 9 1920, and that death occurred, on the date stated above, at 4a. m.

The CAUSE OF DEATH* was as follows:

Ulcer of Stomach

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver

(Duration) yrs. 8 mos. ds.

(Signed) Asa L Wessels M. D.

Aug. 10, 1920 (Address) 2565 Fredericks Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Aug 13, 192a

20-UNDERTAKER Joseph L Cook ADDRESS 1003 N Bond St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45630 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45630

CERTIFICATE OF DEATH.

X 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 N. Paca ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Syntha Harris

(a) RESIDENCE. No. 609 N. Paca ST., WARD. Virginia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Midwife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Edmond Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Della Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Dollie Wilson

(Address): 609 N. Paca St.

15 Date received: AUG 12 1920 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1920

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1920, to Aug 10, 1920, that I last saw h[er] alive on Aug 9, 1920, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Va

Did an operation precede death? none Date of

Was there an autopsy? No

What test confirmed diagnosis? Heart sounds

(Signed) Wm. Lehr Forbes, M. D.

8/11, 1920 (Address) 1116 Dolphin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Scottsville Va	Aug 12 1920
20 UNDERTAKER: Daniel Easley	ADDRESS 911 E. Fayette

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D45631 HEALTH DEPARTMENT—CITY OF BALTIMORE D45631

CERTIFICATE OF DEATH.

91

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 Prince ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Barnes

(Residence in Baltimore: No. 715 Prince St.; ....yrs., 8 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colrd	

6-DATE OF BIRTH, Nov (Month) 15 (Day), 1911 (Year)

7-AGE, ...yrs. 8 mos. 26 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Richard Barnes

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Ward

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Percy J. Ward

(Address) 715 Prince St

15- AUG 12 1920 ROBERT E KRAUTER

Filed....., 191.... Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 10th (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Aug 8 1920, to Aug 10, 1920, that I saw him alive on Aug 10th 1920, and that death occurred, on the date stated above, at 7 a, m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) ....yrs. ....mos. 5 ds.

(Signed) Samuel A Bair M. D.

Aug 11, 1920 (Address) 937 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	Aug 12, 1920
20-UNDERTAKER Brown & Keeland	ADDRESS 114 W. Lexington

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45632 HEALTH DEPARTMENT—CITY OF BALTIMORE D45632

CERTIFICATE OF DEATH. 150

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Hamilton Ave. near Greenfield Ave. ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Kornick Jr

(a) RESIDENCE. No. Hamilton Ave near Greenfield Ave. ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9th 1920

7 AGE — Years — Months — Days 3 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Howard A Kornick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER May Beckman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant (Address) Herman A Kornick Hamilton Md.

15 Filed AUG 12 1920 19 ROBERT P. KRAUTH Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11th 1920

17 I HEREBY CERTIFY, That I attended deceased from August 9, 1920, to August 11, 1920, that I last saw him alive on August 11, 1920, and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cause unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Convulsions - Paralysis

(Signed) Joseph L. Valentine M. D.

8/12 1920 (Address) 2 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug 12th 1920
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Fullerton Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 45633 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45633.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 McElderry St.; 5 WARD) REGISTERED NO. C 19

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph F. Wade

(Residence in Baltimore: No. 1408 McElderry St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Widower

6-DATE OF BIRTH, ... (Month) ..... (Day) 1887 (Year)

7-AGE, 33 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): O.H.C.

9-BIRTHPLACE, (State or Country). N. Carolina

PARENTS.

10-NAME OF FATHER. Abraham Wade

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER Delphia Corrinder

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H. Wade

(Address) 311 N. Stricker St

15. Filed AUG 12 1920 191 C. H. Cross, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 10 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 8th 1920. to Aug 10, 1920. that I saw h[illegible] alive on Aug 10, 1920. and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Acute Nephritis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Aug 14, 1920 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel — DATE OF BURIAL, Aug 13, 1920

20-UNDERTAKER John W Henderson — ADDRESS 1502 E Monument

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45634 1920 38 1882

D45634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospital ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Hester Counters

(a) RESIDENCE. No. 1535 Leslie ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Douglas Counters

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Clem Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Douglas Counters (Address) 1667 Lester St.

15 Filed AUG 12 1920 G. H. Cross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1920.

17 I HEREBY CERTIFY, That I attended deceased from 6-7-20, 19..., to 8-10, 1920; that I last saw her alive on 8-10, 1920; and that death occurred, on the date stated above, at 3.35 P m.

The CAUSE OF DEATH* was as follows:

Placenta Previa - Pregnancy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rupture of Uterus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8-10-20

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) J. Morris Reese, M. D.

8/10. 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters	Aug 13 1920

20 UNDERTAKER Harmon & Wisfield ADDRESS 1364 W. Cary

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

D-45635 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D45635

CERTIFICATE OF DEATH.

104

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 W Preston ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent Simon - Parrino

(Residence in Baltimore: No. 17 W Preston St.; ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	Single

6-DATE OF BIRTH, 6 (Month) 18 (Day) 1920 (Year)

7-AGE, ...yrs. 4 mos. 3 wks 6 ds. If LESS than 1 day, ...hrs. or ....min.

1 mo 23 days

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, John Parrino

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Jennie Simon

13-BIRTHPLACE OF MOTHER (State or Country), Baltocity

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Parrino

(Address) 17 W. Preston St

15- C. H. Grese.

Filed AUG 12 1920 1921 Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 11 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8/6 1920, to 8/11 1920, that I saw h[illegible] alive on 8-10 1920., and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis Colitis

(Duration) ....yrs. ....mos. 8 ....ds.

CONTRIBUTORY.....
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Dr Edward Voss M. D.

8/11, 1920 (Address) 914 E Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral	Aug. 13, 1920
20-UNDERTAKER	ADDRESS
Martin Faherty & Son	452 W North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D45636 HEALTH DEPARTMENT—CITY OF BALTIMORE D45636

+41

CERTIFICATE OF DEATH.

1-PLACE OF DEATH The Howard A. Kelly Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1718 Eutaw Place ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr. Peregrino Rey.

(Residence in Baltimore: No. ..... St.; ..... yrs., ... mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1863
(Month) (Day) (Year)

7-AGE, 57 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Cigar Mfg
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Self

9-BIRTHPLACE, (State or Country), Spain

PARENTS.

10-NAME OF FATHER, Ignacio Rey

11-BIRTHPLACE OF FATHER (State or Country), Spain

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Spain

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ignacio Rey

(Address) Tampa Florida

15-

Filed ....., 191.....

G. H. Crose.
Registrar.

AUG 12 1920

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 11, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 28 1920, to Aug. 11 1920, that I saw him alive on Aug. 11 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

..... Cardiac Failure
..... secondary to Intestinal Cancer
..... (Duration) ✓ yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Intestinal Cancer
..... (Duration) ✓ yrs. 8 mos. 0 ds.

(Signed) Arthur C. Vermoor M. D.

Aug 11, 1920. (Address) 1718 Eutaw Place.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ✓ yrs. ✓ mos. 15 ds. In the State ✓ yrs. ✓ mos. 15 ds.

Where was disease contracted, if not at place of death? Tampa Florida

Former or usual residence Tampa Fla.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Tampa Florida	Aug. 12, 1920

20-UNDERTAKER	ADDRESS
Martin Fahey & Sons	827 N North Av

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-45637 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45637

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3779 Kossuth St. 20 WARD)

2-FULL NAME Gunther Braun

(a) RESIDENCE. NO. 3779 Kossuth ST., 20 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~): Marie A. Braun

6 DATE OF BIRTH (month, day, and year): July 12 1848

7 AGE: Years 72; Months; Days 29; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cigar-Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 011
(c) Name of employer: Gunther Braun

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Frederick A. Braun

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Marie A. Braun - Wife
(Address) 3779 Kossuth St.

15 Filed ....., 19.....

AUG 18 1920

G. H. Cross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1920

17 I HEREBY CERTIFY, That I attended deceased from August 5, 1920, to August 10, 1920, that I last saw him alive on August 10, 1920, and that death occurred, on the date stated above, at 10.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) Henry D Haber M. D.

8/11 1920 (Address) 23 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Aug 13 1920

20 UNDERTAKER: Patrick A. Hannon — ADDRESS: 1911 N. Lombard St

CAUSE OF DEATH in plain terms, so that it may be understood by the public. ATION is very important. See instructions on back of certificates.

D45638 HEALTH DEPARTMENT—CITY OF BALTIMORE D45638

159

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hopkins Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Gray

(Residence in Baltimore: No. 716 Belnord Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	S.

6-DATE OF BIRTH, May (Month) 20 (Day), 1901 (Year)

7-AGE, 19 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balt

PARENTS.

10-NAME OF FATHER Conrad Gray

11-BIRTHPLACE OF FATHER (State or Country). Balt

12-MAIDEN NAME OF MOTHER Mary C Wolfe

13-BIRTHPLACE OF MOTHER (State or Country). Balt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Wolfe

(Address) 716 N Belnord ave

15- A H Carr

Filed AUG 12 1920, 191.... Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 10 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by poison

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm Finnegan (Coroner.) M. D.

8-11, 1920 (Address) 4 E Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge — DATE OF BURIAL, May 13, 1920

20-UNDERTAKER Wendell Bayne & Son — ADDRESS 37 S Mon

D45639 HEALTH DEPARTMENT—CITY OF BALTIMORE D45639

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1700 Williams ST.: 24 WARD) REGISTERED No. C 81

2-FULL NAME Frances E. Holles.

(Residence in Baltimore: No. 1700 Williams St.; yrs. 55 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F. | 4-COLOR OR RACE, White | ~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Widow

6-DATE OF BIRTH, May 25 - 1840 (Month) (Day) (Year)

7-AGE 80 yrs. 4 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dress maker
(b) General nature of industry, business, or establishment in which employed (or employer): g.h.

9-BIRTHPLACE, (State or Country), Germany-

PARENTS.
10-NAME OF FATHER, Beller.
11-BIRTHPLACE OF FATHER (State or Country), Germany-
12-MAIDEN NAME OF MOTHER Not Known
13-BIRTHPLACE OF MOTHER (State or Country), Germany-

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. F. Holles
(Address) 1705 Williams St

15-
Filed OCT 12 1920, 191... G. H. Gresc... Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH. 1pm

16-DATE OF DEATH, 8 (Month) 10 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to d. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Senility-

(Duration) yrs. mos. 1 ds.

(Signed) G. E. Blades M. D. (Coroner.)

8 11 20, 191... (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL Holy Cross & Cs | DATE OF BURIAL, 8/12 1920

20-UNDERTAKER J. F. Lahey & Sons | ADDRESS 131 E. Eight St

D-45640 HEALTH DEPARTMENT—CITY OF BALTIMORE D45640

CERTIFICATE OF DEATH.

175-001

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. South Balto Genl Hospital 13 WARD)

REGISTERED No. C

2-FULL NAME Arthur S. Lowe

(Residence in Baltimore: No. 1729 S. Charles St 40 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ..., 1870
(Month) (Day) (Year)

7-AGE 50 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), England.

PARENTS.

10-NAME OF FATHER, Thos. Lowe

11-BIRTHPLACE OF FATHER (State or Country) England.

12-MAIDEN NAME OF MOTHER, Mary Standish

13-BIRTHPLACE OF MOTHER (State or Country), England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Lowe

(Address) 1721 S Charles St.

15- Filed AUG 12 1920, 191.... G. H. Grese Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8/9/20, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Int Dural Haemorrhage
Cerebral Concussion
accident
(Duration) ....yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Shock
(Duration) ....yrs. mos. 1 ds.

(Signed) Columbus Blades M. D.
(Coroner.)
8/11/20, 191... (Address) 143 N. Bway.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, 8/12, 19 20

20-UNDERTAKER J. J. Fahey & Son — ADDRESS 318 Eight St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Omissions will delay burial certificate. Each statement is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D45641

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45641

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2138 S Fulton Av St.; 19 WARD)

REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christian Gross

(Residence in Baltimore: No. 2138 S Fulton av St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, * ....., 1..... (Month) (Day) (Year)

7-AGE, 74 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Christian Gross

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Joo Trunkand

(Daughter) (Address) 1717 Wilkens Ave

15-

Filed ..... 191.....

AUG 12 1920

ROBERT P. LEE, M.D. Registrar.

Burial Permit Office

AUG 12 1920

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 11, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Aug 11 1920, that I saw him alive on Aug 10 1920, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Cerebral Hemorrhage

(Duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) 4 yrs. ... mos. ... ds.

(Signed) Morton H Cahn M. D.

Aug 12, 191... (Address) 2157 Bellaire Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Farmer or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Aug 13., 1920

20-UNDERTAKER — ADDRESS 2651 Pred Av

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 45642

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45642

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1311 John Street ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Somerell Fuller.

(a) RESIDENCE. NO. 1311 John Street ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widowed

5a ~~Married~~, widowed, or divorced HUSBAND of (or WIFE) of Rosa Somerell Fuller

6 DATE OF BIRTH (month, day, and year) Sept. 9-1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk — 49

(b) General nature of industry, business, or establishment in which employed (or employer) Court of Common Pleas.

(c) Name of employer Adam Dipert. Clerk. Prince Friedrich

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Augustus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Rebecca Somerell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md.

14 Informant Lemuel Tilly Day Funeral (Address) 31 E. Lee St. Balto. Md.

15 Filed AUG 12 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-12 1920

17 I HEREBY CERTIFY, That I attended deceased from August 10 . 1920 . to August 12 . 1920 . that I last saw him alive on August 10 1920. and that death occurred, on the date stated above, at 7 A — m.

The CAUSE OF DEATH* was as follows:

Arteri Sclerosis — Myocarditis —

(duration) Some yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pneumonia — (duration) — yrs. 10 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Physical Examination

(Signed) Hall Harris M. D.

19 (Address) 1327 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvert Co Middleham Chapel Md

DATE OF BURIAL 8-14 1920

20 UNDERTAKER Henry W. Justis & Sons Co

ADDRESS W. Fulton Ave

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 45643

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45643

64

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 N Lanvale St ST. V7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aileen B C Dammann

(Residence in Baltimore: No. 811 N Lanvale St St.; 56 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~. (Write the word.) Married

6-DATE OF BIRTH, January (Month) 21 (Day) 1864 (Year)

7-AGE, 93 yrs. 6 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Richmond Va:

PARENTS.

10-NAME OF FATHER, James A Lowardin

11-BIRTHPLACE OF FATHER (State or Country), Bath Co Va:

12-MAIDEN NAME OF MOTHER Anne Purcell

13-BIRTHPLACE OF MOTHER (State or Country), Richmond Va:

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Francis Dammann

(Address) 811 N Lanvale St

15-

Filed ..... 1920, 191.....

Robert F. Harrison,
Registrar.
Burial Permit Clerk.

AUG 12 1920

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 11th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1st 1920, to August 11 1920, that I saw h er alive on August 11th 1920, and that death occurred, on the date stated above, at 10 00 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

..... (Duration) ..... yrs. 2 mos. 11 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis. Nephritis.

..... (Duration) 4 yrs. ..... mos. ..... ds.

(Signed) O G Chatard M. D.

Aug 11th, 1920 (Address) 40 W. Biddle St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Aug 13, 1920.

20-UNDERTAKER Henry W. Jenkins Sons — ADDRESS McCulloh & Lafayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45644 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45644

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Sparrow

(a) RESIDENCE. No. 829 Pennsylvania Ave. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bennie Sparrow

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Actress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER Jase Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Claudie Weights

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant Hospital Records
(Address) M.T.H.

15 Filed AUG 12 1920 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1920, to Aug. 8, 1920, that I last saw h. alive on Aug. 8, 1920, and that death occurred, on the date stated above, at 9.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. S. Fahndrich. M. D.

8-9-20. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	AUG 12 1920
20 UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health.

Burial Permit Clerk.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45645 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45645

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bayview Hospital REGISTERED NO. 37

CITY OF BALTIMORE: (No. ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Era Parker

(a) RESIDENCE. NO. 333 Forest ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Do
12 MAIDEN NAME OF MOTHER Do
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant Bayview Hosp
(Address) Balto. Md.

15 Filed AUG 12 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11, 1920

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1920, to Aug. 11, 1920, that I last saw h alive on Aug 10, 1920, and that death occurred, on the date stated above, at 6 15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Lues + Delirium

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? Serological

(Signed) N. Hedsmith, M. D.

, 19 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Aug 13 1920

20 UNDERTAKER ADDRESS
F. L. Brownson 108 Monday

TION is very important. See instructions on back of c
k of certificates.

D.45646 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45646

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2108 bis St.: 20 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nicholas Schneider

(Residence in Baltimore: No. 2108 bis St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Aug 11, 1920 (Month) (Day) (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, 20 hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Nicholas Schneider

11-BIRTHPLACE OF FATHER (State or Country) Hungaria

12-MAIDEN NAME OF MOTHER Emma Lutz

13-BIRTHPLACE OF MOTHER (State or Country), Hungaria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nicholas Schneider

(Address) 2108 bis St

15- Filed ..... 191.....

Robert P. Harrison, Registrar.

AUG 12 1920 Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 11, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Foraman Oval
Insufficiency
(Duration) ..... yrs. / mos. 20 ds.
CONTRIBUTORY (Secondary) Congenital
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James H. Fenton M. D. (Coroner.)
Aug 12, 1920 (Address) 700 E Chase St

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Aug 12, 1920

20-UNDERTAKER Geo. A. Lubig

ADDRESS 2001 W. Baltimore St

Spec.—8-24-14—M. & T.—2000 Bks.

045647 HEALTH DEPARTMENT—CITY OF BALTIMORE 045647

CERTIFICATE OF DEATH.

64-010

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3712 Park Heights Av ST.; 45 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Moses adler

(Residence in Baltimore: No. 3712 Park Heights Av St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH Sept 14, 1843
(Month) (Day) (Year)

7-AGE, 76 yrs. 8 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... Hotel Proprietor

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Phillip adler

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Jennie Strauss

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lew Rembardt

(Address) 3712 Park Heights Av

15- Filed AUG 12 1920, 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 10, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 21 1920, to Aug 10 1920, that I saw h[illegible] alive on Aug 10 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ....yrs. ....mos. 19 ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(Duration) ....yrs. ....mos. 2 1/2 ds.

(Signed) [illegible] M. D.

8-12, 1920. (Address) 1531 E. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	8/13..., 1920.
20-UNDERTAKER J A Ahrens & Co	ADDRESS 16 N Howard

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45648 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45648

CERTIFICATE OF DEATH. X 74

1-PLACE OF DEATH REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Franklin & Schroeder ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pauline Smith

(Residence in Baltimore: No. Nursery & Childs Hospital ST.: ? yrs., ? mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. July 17, 1918 (Month) (Day) (Year)

7-AGE. 2 yrs. ? mos. 20 ds.

If LESS than 1 day, ? hrs. or ? min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. ———
(b) General nature of industry, business, or establishment in which employed (or employer). ———

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Ray H. Smith

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Botana Bender

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. P. Sabin

(Address) ? + Childs Hospital

15- Edwin P. Harrison, J

Filed AUG 12 1920 191 Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug. 12, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 30 191?, to Aug 12 1920, that I saw her alive on Aug 11 1920, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Pittlers Disease
(Congenital Spastic Paralysis)

(Duration) 2 yrs. ? mos. 20 ds.

CONTRIBUTORY (Secondary) ?

(Duration) ? yrs. ? mos. ? ds.

(Signed) Lowell S. Rives M. D.

August 12, 1920 (Address) 1002 E. Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ? yrs. ? mos. 13 ds. In the State 2 yrs. ? mos. 20 ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Frederick, Md.

19-PLACE OF BURIAL OR REMOVAL. Frederick Md

DATE OF BURIAL. Aug. 13., 1920

20-UNDERTAKER W. M. Mantown Thomas J. Price

ADDRESS Frederick

important. See instructions on back of certificate.

D.45649 HEALTH DEPARTMENT--CITY OF BALTIMORE D.45649

CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. House of the Good Shepherd St. 19 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Holter

(Residence in Baltimore: No. House of the Good Shepherd St. Life yrs. mos. ds.)
3400 Old York Mount & Hollins Sts.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female | 4-COLOR OR RACE: White | 5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Feb. (Month) 25 (Day), 1884 (Year)

7-AGE: 36 yrs. 5 mos. 16 ds. | If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Sewing
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Upper Falls, Md

PARENTS

10-NAME OF FATHER: William Holter

11-BIRTHPLACE OF FATHER (State or country): Near Fredrm Pa

12-MAIDEN NAME OF MOTHER: Mary E Weis

13-BIRTHPLACE OF MOTHER (State or country): Near Fredrm Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sister of the Good Shepherd

(Address) Mount & Hollins St

15. AUG 12 1920 Robert P. Harrison, 191 Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: August (Month) 10 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20, 1920, to August 10 1920, that I saw h- alive on August 2, 1920, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 2 yrs. ... mos. ... ds

Contributory (SECONDARY) Bronchial asthma

(Duration) ... yrs. 3 mos. ... ds.

(Signed) Jennie M. Brown M. D.

Aug 10, 1920 (Address) 570 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. | In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mount Olivet Cemetery | DATE OF BURIAL: 8/13 1920

20-UNDERTAKER: J. J. Talbert & Son | ADDRESS: 1318 Eight St

N.B.-Every item of information must be answered, so that it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.456 50 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.456 50

CERTIFICATE OF DEATH.

REGISTERED NO. 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital (St.) 25 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wellons Warner

(a) RESIDENCE. No. 652 Indiana Ave (St.) Westport. (Ward.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Warner.

6 DATE OF BIRTH (month, day, and year) June 31 - 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
48		1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Riveter

(b) General nature of industry, business, or establishment in which employed (or employer): ship

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore - Md.

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): md.

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md.

14 Informant (Address): Mary Warner 652 Indiana Ave - Westport

15 Filed AUG 12 1920 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 11 1920

17 I HEREBY CERTIFY, That I attended deceased from June 28 . 1920 . to August 11 . 1920 .

that I last saw him alive on August . 11 . 1920 .

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Adeno Carcinoma of Mediastinum Lymph. Glands. with. General Metastasis.

(duration) (?) yrs. 6. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings & X-Ray.

(Signed) C. Tilden Stewart M.D.

8/11. 1920 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park.	Aug 14 1920
20 UNDERTAKER: William Coof	ADDRESS: 5022 Kort Ave

CAUSE OF DEATH—Information is very important. See instructions on back of certificates.

(Burial Permit Clerk)

D.45651 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45651

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S.P.H.S.Hospital #56 St.; 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Lloyd Kemp

(Residence in Baltimore: No. 653 W. Lexington St., Baltimore St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	White	Married

6-DATE OF BIRTH. Unknown (Month), (Day), 1 (Year)

7-AGE. 25 yrs. XXXX XXX

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar J. Rosenbaum Capt.

(Address) Fort McHenry Baltimore Md.

15-

Filed AUG 12 1920, 191

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 12, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 28, 1920, to August 12, 1920, that I saw him alive on August 12, 1920, and that death occurred, on the date stated above, at 11:55 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, chronic pulmonary

(Duration) 2 yrs. 9 mos. -- ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thomas R. Payne M. D.

Aug. 12, 1920 (Address) Fort McHenry, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death -- yrs. -- mos. 16 ds. In the State Md. yrs. -- mos. 16 ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 653 W. Lexington St. Balto. Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
London Park	Aug. 14, 1920
20-UNDERTAKER	ADDRESS
William Cook	502 E North Ave.

Important. See instructions on back of certificate.

D45652 HEALTH DEPARTMENT—CITY OF BALTIMORE D45652

CERTIFICATE OF DEATH.

1813

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2534 Mosher ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Irene Taylor

(Residence in Baltimore: No. 2534 Mosher St. St.; 7 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	single

6-DATE OF BIRTH, August 10, 1920
(Month) (Day) (Year)

7-AGE, 7 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Millard A. Taylor

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Eva Irene Taylor

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Millard A. Taylor

(Address) 2534 Mosher St.

15- Filed AUG 13 1920, 191 G. Grese Registrar.

G. F. Grese.

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 10, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Electrocution by coming in contact with live wire, the property of C. & P. Tel. Co. (Telephone held negligent Immediate

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Hennessy M. D.
(Coroner.)

August 13 1920 (Address) 2502 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Elkton Cecil Co. Md	Aug 13., 1920
20-UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson Ave

Spec.—8-24-14—M. & T.—2000 Blks.

D45653

HEALTH DEPARTMENT—CITY OF BALTIMORE

1042 D45653

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 705 George ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Green

(Residence in Baltimore: No. 705 George St.; ....yrs., 15 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ..., 1919
(Month) (Day) (Year)

7-AGE, 1 yrs. 8 mos. ....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Born in Baltimore City

PARENTS.

10-NAME OF FATHER, Charles Green, Sr

11-BIRTHPLACE OF FATHER (State or Country), born in Baltimore

12-MAIDEN NAME OF MOTHER Nellie Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie Green

(Address) 705 George St

15- AUG 13 1920 Filed ....., 191.... C. H. Grace, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 11, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1920, to Aug 11 1920, that I saw h im alive on Aug 11 1920, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

..... (Duration) ....yrs. ....mos. 22 ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) H. B. Hughes M. D.

Aug 11, 1920 (Address) 724 W. Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Aug 13, 1920

20-UNDERTAKER Mrs R A Elliott — ADDRESS 1205 Ashland Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45654

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45654

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 N.Castle St. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Mitchell

(a) RESIDENCE. NO. 526 N.Castle St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 9 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas R.Mitchell

6 DATE OF BIRTH (month, day, and year): Nov.10 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	9	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House-wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

000

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John R.Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sarah A.Bratt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Mrs.Emerson C.Baily
(Address) 526 N.Castle St.

15 Filed AUG 13 1920 G. H. Cress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) AUG.10 1920

17 I HEREBY CERTIFY, That I attended deceased from 7-31, 1920 to 8-10, 1920
that I last saw h.. alive on 8-9, 1920
and that death occurred, on the date stated above, at 5.30 A. m.
The CAUSE OF DEATH* was as follows:

Acute End-conditis
Mitral Regurgitation merked
Dyspnoea (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Cardiac dilatation
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Findings
(Signed) Fred Burnick M. D.
8 10 1920 (Address) 800 N.Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MOUNT OLIVET. DATE OF BURIAL: AUG 13 1920

20 UNDERTAKER: JOHN F. DENNY ADDRESS: 715 LIGHT ST.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45655 HEALTH DEPARTMENT—CITY OF BALTIMORE D45655

CERTIFICATE OF DEATH. 104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 W Lexington ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Gannon.

(a) RESIDENCE. No. 1523 W Lexington ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Febry 13th 1920.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	5	29.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. J. Gannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Vesta Longstreth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pittsburg Pa.

14 Informant Mrs Wm. J. Gannon
(Address) 1523 W Lexington St.

15 Filed AUG 13 1920 19 C. H. Greer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12. 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 8 1920, to Aug. 12 1920, that I last saw h~~im~~ alive on Aug. 11. 1920, and that death occurred, on the date stated above, at 3 40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis,

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no. —

What test confirmed diagnosis? None.

(Signed) Thos. Gorton, M. D.

Aug. 13 1920 (Address) 888 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cem.	Aug. 13th 1920
20 UNDERTAKER	ADDRESS
John J. Gowan & Son.	901 Hollins St.

CAUSE OF DEATH. Should be stated by the physician in plain English terms, so that it can be understood by the general public. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45656

CERTIFICATE OF DEATH.

64 D45656

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 351 S. Stricker ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anney Kennedy

(Residence in Baltimore: No. 351 S. Stricker St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH: Unknown (Month) (Day), 1861 (Year)

7-AGE: 59 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): ooo

9-BIRTHPLACE, (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: J. Boyd

11-BIRTHPLACE OF FATHER (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Kennedy

(Address) 351 S. Stricker St.

15-

Filed ....., 191.....

AUG 13 1920 G. H. Cress. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 11, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 14 1920, to August 11 1920, that I saw her alive on August 11 1920, and that death occurred, on the date stated above, at 10.45 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(Duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Senile Arterio sclerosis

(Duration) over yrs. 2 mos. ds.

(Signed) Henry C. O'Neill M. D.

Aug 12, 1920 (Address) 1203 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park. DATE OF BURIAL: Aug 14th, 1920

20-UNDERTAKER: John J. Cowan & Son ADDRESS: 901 Baltimore St.

Important. See instructions on back of certificate.

D45657 HEALTH DEPARTMENT—CITY OF BALTIMORE D45657

CERTIFICATE OF DEATH.

REGISTERED No. C 64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2302 Etting St.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte Reid

(Residence in Baltimore: No. 2302 Etting St. St.: 11 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1846 (Year)

7-AGE, 74 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Duties
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James N. Galloway

(Address) 2302 Etting St.

15- Filed AUG 13 1920 191 G. H. Cook Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 10, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 1 yrs. mos. ds.

(Signed) J. D. Hennessy M. D. (Coroner.)

Aug 10, 1920 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn DATE OF BURIAL, Aug 16, 1920

20-UNDERTAKER JAMES K. DENNIS ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH to be plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

845658 HEALTH DEPARTMENT—CITY OF BALTIMORE 1/2 45658

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St. Joseph's Hospital St.: 6 WARD)

2-FULL NAME Adolph Furst

(a) RESIDENCE. NO. 1916 Orlean ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18	9		

8 OCCUPATION OF DECEASED 603

(a) Trade, profession or particular kind of work Bakers. apprentice

(b) General nature of industry, business, or establishment in which employed (or employer) Baking Establish

(c) Name of employer John Haber

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER August Furst.

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Fischer

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Barbara Kleiner
(Address) 627 S. Kenwood Ave.

15 Filed AUG 13 1920 19.. G H Cross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12 1920

17 I HEREBY CERTIFY, That I attended deceased from August 3 1920 to Aug. 12 1920

that I last saw him alive on im dead Aug. 12 1920

and that death occurred, on the date stated above, at 3:40 A. m.

The CAUSE OF DEATH* was as follows:

Haemorrhage, Intestinal

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Typhoid Fever

(duration) ....yrs. ....mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Sign

(Signed) I. B. Bromsheas M. D.

8-12 1920 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	14 " 1920
20 UNDERTAKER Lilly and Zieb.	ADDRESS 403 S. Mo[illegible] St.

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45659 HEALTH DEPARTMENT—CITY OF BALTIMORE D45659

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Hubbert

(a) RESIDENCE. No. 2820 Elliott Av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Hubbert.

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
73	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md -

PARENTS

10 NAME OF FATHER Timothy Hynes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland -

12 MAIDEN NAME OF MOTHER Mary Clisham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records of Mt Hope Retreat (Address) Mount Hope Balto. Md.

15 Filed AUG 13 1920, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 1894, 19, to Aug 11, 1920, that I last saw her alive on Aug 11, 1920, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary) Chr Mania

(duration) 40 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md -

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug 13 1920

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. [redacted], Successor)

ADDRESS 108 W. NORTH AVE

CAUSE OF DEATH: PLEASE WRITE PLAINLY. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D45660 HEALTH DEPARTMENT—CITY OF BALTIMORE D45660

CERTIFICATE OF DEATH.

98

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 Carrel ST.; 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lottie Young

(Residence in Baltimore: No. 221 Carrel St.; 23 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb 3 (Month) (Day) 1897 (Year)

7-AGE, 23 yrs. ~ mos. ~ ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country). Balto Co Md

PARENTS.

10-NAME OF FATHER. Harry Young

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER. Sephrina Neal

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Young

(Address) 221 Carrel St

15-

Filed....., 191.... G. H. Grese, Registrar.

AUG 13 1920

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 11 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1920, to Aug 11 1920, that I saw her alive on Aug 11 1920, and that death occurred, on the date stated above, at 5 P, m.

The CAUSE OF DEATH* was as follows:

Pulmonary Consumption

Past Year (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Usual Causes

(Duration) ... yrs. ... mos. ... ds.

(Signed) Samuel A Dass M. D.

Aug 12 1920 (Address) 937 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St Helena

DATE OF BURIAL. Aug 13 1920

20-UNDERTAKER Daniel Easter

ADDRESS 916 Penna ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 45661

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45661

CERTIFICATE OF DEATH.

REGISTERED NO. C 42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1320 Morling Av ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Martin

(Residence in Baltimore: No. 1320 Morling Ave St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Mar 23, 1846 (Month) (Day) (Year)

7-AGE, 74 yrs. 4 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Balto Co

PARENTS.

10-NAME OF FATHER, Daniel Robinson

11.-BIRTHPLACE OF FATHER (State or Country), Balto Co

12-MAIDEN NAME OF MOTHER, Mary L Wenger

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs B Martin

(Address) 1320 Morling Ave

15-

Filed ....., 191.... G. H. Grese, Registrar.

AUG 13 1920

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 12, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1918, to Aug 12 1920, that I saw her alive on Aug 11 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Carcinoma involving the pelvic organs starting in Uterus (Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Dr. Wade H. P., M. D.

8/13, 1920 (Address) 2020 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Carroll Chapel — DATE OF BURIAL, Aug 16..., 1920

20-UNDERTAKER A. S. Mask — ADDRESS Ed 353 Fulton

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45662 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45662

D45662

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 941 Druid Hill ave ST.; 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Hooper

(a) RESIDENCE. No. 941 Druid Hill ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
4 mos 15 ds	dec 1920	mar.	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. md.

PARENTS

10 NAME OF FATHER William Hooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co. Md

12 MAIDEN NAME OF MOTHER Elsie Stanley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co. Md.

14 Informant William Hooper (Address) 941 Druid Hill ave

15 Filed ..., 19... AUG 19 1920 C. H. Grove Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/12/1920

17

I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1920, to Aug 12, 1920

that I last saw him alive on Aug 12, 1920,

and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia, about 6 hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro Enteritis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Jno. H. Tompkins M. D.

(Address) 1019 Druid Hill ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 13 1920
20 UNDERTAKER	ADDRESS
Jno. Geo. Hooper	406 N. Eutaw

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-45663

CERTIFICATE OF DEATH.

151 D 45663

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Cohen

(Residence in Baltimore: No. Hebrew Hospital St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Sgl

6-DATE OF BIRTH. Aug. 12, 1920 (Month) (Day) (Year)

7-AGE. ..... yrs. ✓ mos. ..... ds.

If LESS than 1 day, 1 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md —

PARENTS.

10-NAME OF FATHER, William Cohen

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary Cohen

13-BIRTHPLACE OF MOTHER (State or Country), Russia —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Balto St

15-

Filed ....., 191.....

AUG 13 1920 G. H. Gross Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 12, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 12 1920, to Aug 12 1920, that I saw h[illegible]alive on Aug. 12 1920, and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows:

Asphyxia Monoxide

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature ity

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry Goldman M. D.

Aug 13, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 2761 W Baltimore

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mt Carmel — DATE OF BURIAL, Aug 13, 1920

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto

Spec.—8-24-14—M. & T.—2000 Blks.

D 45664 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45664

CERTIFICATE OF DEATH.

REGISTERED NO. C 108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Steinberg.

(Residence in Baltimore: No. 301 Low St. St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH. Unknown (Month) (Day), 1906 (Year)

7-AGE. 14 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE (State or Country), Balt md

PARENTS.

10-NAME OF FATHER, Louis Steinberg

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Esther S—

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 Eutaw St

15- Filed AUG 13 1920, 191... G. H. Grese Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 13 (Day), 1920 (Year).

17. I HEREBY CERTIFY, That I attended deceased from August 11 1920, to August 13 1920, that I saw her alive on August 13 1920, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

(Pneumonia (Post operative)

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Appendicitis Operated on

Sept 7 (Duration) yrs. mos. 5 ds.

(Signed) Louis Weber M. D.

Aug 13, 1920. (Address) The Hebrew Hospital

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 301 Low St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Woodlawn — DATE OF BURIAL, 8/13, 1920

20-UNDERTAKER Jack Lewis — ADDRESS 1411 Eutaw

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45665 HEALTH DEPARTMENT—CITY OF BALTIMORE 50 D 45665

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 S. Clinton St. 26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Yeager

(a) RESIDENCE. No. 1603 S. Clinton St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Yeager

6 DATE OF BIRTH (month, day, and year) Jan. 16. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Conrad Haas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant George Yeager
(Address) 1603 S. Clinton St

15 Filed AUG 13 1920, 19 Registrar G. H. Grese

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11 1920

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1920, to Aug. 10, 1920, that I last saw h.. alive on Aug. 10, 1920; and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician's exam.

(Signed) H. B. Haley, M. D.

Aug 13, 1920 (Address) 2504 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem.	Aug 14 1920
20 UNDERTAKER	ADDRESS
L. Sander Sons	1310 Park Ave

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D 45666

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45666

150

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen'l Hosp. St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Naomi Loraine Staffman

(a) RESIDENCE. No. Royal Oak Ave. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 10, 1920

7 AGE: Years | Months | Days 1 | If LESS than 1 day, 20 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md. [illegible]

PARENTS

10 NAME OF FATHER Charles Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Peddicord

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co. Md.

14 Informant Edwin Hoffman (Address) Royal Oak Ave

15 Filed AUG 13 1920 19 G. H. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1920, to Aug. 12, 1920, that I last saw her alive on Aug 12, 1920, and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows: Patent Foramen Ovale

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred B. Smith, M. D.

19 (Address) M. G. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Aug 13th 20

20 UNDERTAKER: Latham & Jones — ADDRESS: 1733 N. Eutaw [illegible]

CAUSE OF DEATH to be plainly written in ink. See instructions on back of certificates. TION is very important.

Spec—2 31 14—M & T—1000 Blks

HEALTH DEPARTMENT--CITY OF BALTIMORE

D45669

D45669

104

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25 So Robynson ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmer V. Sayller

(Residence in Baltimore: No. 25 So Robinson St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March (Month) 28 (Day), 1920 (Year)

7-AGE, ... yrs. 4 mos. 16 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Chas A Sayller

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Fannie L. Albers

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas A Sayller

(Address) 25 So Robinson

Filed AUG 13 1920 ..... 19.. C. H. Grimes Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 12 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 6 1920, to Aug 12 1920, that I saw him alive on aug 12 1920 and that death occurred, on the date stated above, at 830 a m.

The CAUSE OF DEATH* was as follows: Gastro Enteritis

(Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(Duration) ..... yrs. ..... mos. 8 ds.

(Signed) Maxwell L. Mayer M. D.

8.13.20, 191.. (Address) 311 E Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem — DATE OF BURIAL, Aug 14 1920

20-UNDERTAKER A Kervis & Co — ADDRESS 2008 Orleans

important. See instructions on back of certificate.

D45668 HEALTH DEPARTMENT—CITY OF BALTIMORE 64 D45668

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 316 S Spring ST. 3 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Young
(Residence in Baltimore: No. 316 S Spring St
St.; yrs. 34 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
4-COLOR OR RACE, Negro
5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widowed
6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1877 (Year)
7-AGE, 43 yrs. ..... mos. ..... da.
If LESS than 1 day, ...hrs. or ....min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Own
9-BIRTHPLACE (State or Country), Ala

PARENTS.
10-NAME OF FATHER, James Atkinson
11-BIRTHPLACE OF FATHER (State or Country). Ala
12-MAIDEN NAME OF MOTHER Unknown
13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M E Young
(Address) 416 N Spring St

15-
Filed AUG 13 1920 191.... C. H. Cross Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 10 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy
(Duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... (Coroner) ..... M. D.
(Address) 1804 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. | DATE OF BURIAL, Aug 13 1920
20-UNDERTAKER Samuel E Wemsley | ADDRESS 518 N Bond St

N.B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D45669 HEALTH DEPARTMENT—CITY OF BALTIMORE D45669

D45669 CERTIFICATE OF DEATH. Froggett 28 v

1-PLACE OF DEATH REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2006 W. Pratt ST.; 20 WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME E. Robert. Leoggett.

(Residence if in Baltimore: No. 2006 W. Pratt St. St. 33 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Marrid

6-DATE OF BIRTH, Sept. 12, 1881
(Month) (Day) (Year)

7-AGE, 38 yrs. 10 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Grocer Clerk.
(b) General nature of industry, business, or establishment in which employed, (or employer)..... Meat Cutter 0.S.

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Mercer Froggett.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Rebecca Owens

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mattie Froggett

(Address) 2006 W. Pratt St

15-

Filed AUG 13 1920, 191.. C. H. Grese. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 12, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1920, to Aug 12 1920, that I saw h— alive on Aug 12 1920 and that death occurred, on the date stated above, at 9 30 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. A. Phillips M. D.

Aug. 12 1920 (Address) 2539 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Aug 13/20

20-UNDERTAKER Geo. E. Lohmeyer & Bro. — ADDRESS 101 Eutaw Ave

Cross out words not important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D45670 HEALTH DEPARTMENT—CITY OF BALTIMORE D45670

CERTIFICATE OF DEATH. 1041

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Townsend Av. St.: Brooklyn 25 WARD) REGISTERED NO.

2-FULL NAME Howard Della Uroten

(a) RESIDENCE. NO. Townsend Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		15	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles W. Uroten

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louise Edelmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs C Uroten
(Address) Townsend Av. Brklyn Md

15 Filed AUG 13 1920 G. H. Gross.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 11, 1920, to Aug 12, 1920, that I last saw him alive on Aug 12, 1920 and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) asphyxia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward Novak, M. D.

, 19 (Address) 821 N. Pat Pk. Av Balto.

*State the Disease Causing Death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	8/14 19
20 UNDERTAKER	ADDRESS
Mrch. E. Evans	1448 L

mation should be carefully supplied. Age, CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45671

D45672

CERTIFICATE OF DEATH.

REGISTERED NO. 150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 324 Font. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. H. White.

(a) RESIDENCE. No. 324 Font ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 12 1920

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md
(State or country)

PARENTS

10 NAME OF FATHER Chas. H. White.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Margaret Gibson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto, Md

14 Informant Chas. H. White
(Address) 324 Font Ave.

15 Filed AUG 13 1920 19 C. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1920, to Aug. 12, 1920, that I last saw him alive on Aug. 12, 1920 and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Apnea Foramen Ovale

(duration) Few hrs. mos. da.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. T. Bealmear, M. D.

Aug 13 1920 (Address) 608 Font.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cedar Hill Cem	8/13 1920
20 UNDERTAKER	ADDRESS
J. F. McCully	130 E Font

CAUSE OF DEATH in [illegible] TION is very important. See instructions on back of certificates.

D45672 HEALTH DEPARTMENT—CITY OF BALTIMORE D45672

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital ST 5 WARD) REGISTERED No. C 1832

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Paul (Nee Borofsky)

(Residence in Baltimore: No. 2516 Colvin St St.; yrs., mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	Col-	Married Single

6-DATE OF BIRTH, June 14, 1894 (Month) (Day) (Year)

7-AGE, 26 yrs. 1 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Camden S. C.

PARENTS.

10-NAME OF FATHER, James Paul-Russia

11-BIRTHPLACE OF FATHER (State or Country), S. C.

12-MAIDEN NAME OF MOTHER, Cynthia Arthur

13-BIRTHPLACE OF MOTHER (State or Country), S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. W. Harper

(Address) Salem N. C.

15- AUG 13 1920 Filed, 1920 C. H. Crose, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 10, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Knife Wounds of Neck
Homicide

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hemorrhage

(Duration) ... yrs. ... mos. ... ds.

(Signed) Geo. Edmondson Blades M. D.
(Coroner.)

8/11/20 (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Salem N. C	Aug 13 1920
20-UNDERTAKER Geo W Holland	ADDRESS 163 Patton Ave Asheville

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

045673

HEALTH DEPARTMENT—CITY OF BALTIMORE

045673

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Vermont ave (Irvington) ST.) 28 (WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Fricker

(Residence in Baltimore: No. 8 Vermont ave (Irvington) 64 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 26 (Day), 1856 (Year)

7-AGE, 64 yrs. mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Book Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): Dr.

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John A Fricker

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Jane Evans

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lizzie B. Fricker

(Address) 8 Warmont ave (Irvington)

15- AUG 13 1920 Robert P. Harrison, Registrar.

Filed ....., 191.... Burial Permit Clerk.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 12 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 6 19[illegible], to August 12 1920, that I saw h[illegible] alive on August 10 1920, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Fatal Haemoptysis

(Duration) a few minutes

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

(Signed) W. C. Sandrock M. D.

Aug. 13 1920 (Address) 1242 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Aug. 14..., 1920

20-UNDERTAKER Henry Lutz

ADDRESS 1007 N. Bond St

D.45674 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45674

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2026 Fairmount St. 6 WARD) REGISTERED NO. C 151

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Hall Jr.

(Residence in Baltimore: No. 2026 Fairmount St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Mal	white	Bay

6-DATE OF BIRTH, Aug 12, 1920
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 27 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Boy,
(b) General nature of industry, business, or establishment in which employed (or employer) ..... ood

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, John Hall
11-BIRTHPLACE OF FATHER (State or Country), Balt
12-MAIDEN NAME OF MOTHER Anna Schreyer
13-BIRTHPLACE OF MOTHER (State or Country), Balt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Hall

(Address) 2026 Fairmount ave

15- Robert P. Harrison,
Registrar.

AUG 13 1920, 191 ..... Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos Pooley M. D.
(Coroner)

....., 191... (Address) 2520 ....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Fairview Cemetery	Aug 13, 1920
20-UNDERTAKER	ADDRESS
Randall Offutt	372 N ...

CAUSE OF DEATH in plain terms, so that it may be properly classified. All questions must be answered if possible, as they are important. See instructions on back of certificate.

D.45675

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

8 D. 45675

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE (No. 2906 Riggs Avenue St.; 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Hattie M. Curry

(Residence in Baltimore: No. 2906 Riggs Avenue St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~SINGLE~~ MARRIED ~~WIDOWED~~ OR ~~DIVORCED~~ (Write the word): Married

6 DATE OF BIRTH: November 11 (Month) — (Day), 1877 (Year)

7 AGE: 47 yrs. 8 mos. 1 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None 037
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Frederick A. Wiest

11 BIRTHPLACE OF FATHER (State or country): Frederick, Md.

12 MAIDEN NAME OF MOTHER: Harriet S. Davis

13 BIRTHPLACE OF MOTHER (State or country): Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter A. Curry

(Address) 2906 Riggs Avenue

15 AUG 13 1920, 191 — Robert P. Harrison, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: August 12 (Month) (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to August 12, 1920, that I saw h[illegible] alive on August 11, 1920, and that death occurred on the date stated above, at 8.30 a m.

The CAUSE OF DEATH* was as follows:

Anemia - Aneurism Aorta - Ruptured.

(Duration) yrs. 2 mos. 11 ds

Contributory (SECONDARY) .....

(Duration) yrs. mos. ds.

(Signed) Henry M. Stevenson M. D.

Aug 12, 1920 (Address) 102 West Lafayette Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: London Park. DATE OF BURIAL: Aug 14, 1920

20 UNDERTAKER: George J. Smith ADDRESS: Eutaw St

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D.45676 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45676

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. S.W. Cor Fulton Ave and Franklin St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta Olsen.

(Residence in Baltimore: No. Home for the Aged of the M E Church St.; 48 yrs. ~ mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
~~White~~ Female	White	Single

6-DATE OF BIRTH, July (Month) 10 (Day), 1848 (Year)

7-AGE, 72 yrs. 1 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) West India Islands.

PARENTS.

10-NAME OF FATHER, Christian Olsen

11-BIRTHPLACE OF FATHER (State or Country) West India Islands.

12-MAIDEN NAME OF MOTHER Ingbrig Gausen

13-BIRTHPLACE OF MOTHER (State or Country), West India Islands

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Cuddy

(Address) 400 N. Fulton Ave.

15-

Filed ..... 191.....

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 13 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1920, to Aug 13 1920; that I saw her alive on Aug. 12 1920; and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ~ yrs. ~ mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 2 yrs. ~ mos. ~ ds.

(Signed) Geo. L. Shannon M. D.

Aug 13, 1920 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Aug 14, 1920
20-UNDERTAKER	ADDRESS
George J. Smith	1220 Fulton Ave

important. See instructions on back of certificate.

AUG 16 1920

Spec.—8-24-14—M. & T.—2000 Blks.

20.45677 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.45677

CERTIFICATE OF DEATH.

392

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 S. Parrish ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Etta S. Rommel

(Residence in Baltimore: No. 403 S. Parrish St.; ....yrs., ...mos. ....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 16 (Day), 1894 (Year)

7-AGE, 26 yrs. mos. 26 da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm. T. Sweet

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Annie Grimes

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Esther H. Rommel

(Address) 403 S. Parrish St.

15- Robert P. Harrison,
Filed ....., 191...
Registrar.
Burial Permit Clerk.

AUG 13 1920

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 11 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 19 1920, to Aug 11 1920, that I saw her alive on Aug. 11 1920, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Sarcoma of Right Tonsil

(Duration) yrs. 3 mos. ....da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) John H. Gladowsky M. D.

Aug. 12, 1920 (Address) 638 Columbia Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence 403 S. Parrish St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill cemetery	Aug. 14, 1920
20-UNDERTAKER,	**ADDRESS**
Jones Dignan & Son	1000 S. Paca St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45678

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45678

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH (No house number)

CITY OF BALTIMORE: (No. W. Hamilton ST.: Baltimore 27 WARD)

2-FULL NAME Sophia Hettinger

(a) RESIDENCE. No. W. Hamilton ST., Baltimore WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Wht	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Hettinger

6 DATE OF BIRTH (month, day, and year) Feb 16 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Lilleich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Bauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs C. G. Stomp

(Address) West Hamilton St.

15 Filed AUG 13 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1920

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1920, to August 11th, 1920, that I last saw h[er] alive on August 11th, 1920, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Pyloric end of Stomach.

several months (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Starvation

(duration) yrs. 1 mos. 26 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of None

Was there an autopsy? None.

What test confirmed diagnosis? Vomiting & Constipation

(Signed) George C. C. Vogler M. D.

8/13, 1920 Address 1060 Edmondson Ave & Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem Cem	Aug 14 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 E. Baltimore

CAUSE OF DEATH must be given. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.45679

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45679

CERTIFICATE OF DEATH.

69

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2511 Elsinor Ave ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Elizabeth Bosley,

(a) RESIDENCE. No. 2511 Elsinor Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 6.1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm.Bosley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co.Md.

12 MAIDEN NAME OF MOTHER Jane E.Colston,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Sophie G.Bosley,
(Address) 2511 Elsinor Ave

15 Filed AUG 13 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 6, 1920, to Aug 13, 1920.

that I last saw h[illegible] alive on Aug 13, 1920.

and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac collapse following exhaustion ? Statens Epilepticus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Statens Epilepticus

(duration) [illegible] yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Arthur L Fehrenbach M. D.

8/13 1920 (Address) 2806 Garrison E

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys.Govans	Aug.16 1920
20 UNDERTAKER Geo. W. Little	ADDRESS 531 N. Fremont Av

CAUSE OF DEATH in plain words. Do not use abbreviations or technical terms. Consult your family physician if necessary. Your certificate should show the cause of death which you would write on your own family record. TION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

20.45680 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.45680

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2646 E. Oliver ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Hukka.

Residence in Baltimore: No. 2646. E. Oliver St.; 43 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	married

6-DATE OF BIRTH, May (Month) 15 (Day), 1867 (Year)

7-AGE,	If LESS than 1 day,
53 yrs. 2 mos. 26 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Joseph Hukka.

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Mrs. Berner

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antoinette Hukka.

(Address) 2646 E. Oliver

15- Robert P. Harrison, Registrar.

AUG 13 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 11 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 2 1919, to Aug 11 1920, that I saw him alive on Aug 11 1920, and that death occurred, on the date stated above, at 5.20 P m.

The CAUSE OF DEATH* was as follows:

Chronic ulcerative pulmonary tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Interstitial

(Duration) yrs. mos. ds.

(Signed) Leon K. Fargo M. D.

Aug 13, 1920. (Address) 746 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary Cemetery

DATE OF BURIAL, Aug 17., 1920

20-UNDERTAKER W M Roulson

ADDRESS 230 N Greene

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

20.45681

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.45681

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Ingleside Ave. W. Arlington 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith Affley

(Residence in Baltimore: No. Ingleside Ave. W. Arlington St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, August 10, 1920
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
.....yrs. .....mos. 3 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Richard Lemon Affley

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER Bessie B. Hartz

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard L. Affley

(Address) Ingleside Ave.

15-

Filed AUG 13 1920, 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 13, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1920, to Aug 13 1920, that I saw h[illegible] alive on Aug 13 1920, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

.....Bronchial Pneumonia.....

.....

.....

..... (Duration).....yrs.....mos. 1 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos.....ds.

(Signed) C. G. Davies M. D.

8-12, 1920 (Address) 800 W 33rd St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Aug 14, 1920
20-UNDERTAKER Geo. H. Smith	ADDRESS

D.45682 Psalidas D.45682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital ST.; 13 WARD) 6 Y-001
REGISTERED No. C.....
(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emanuel Psalidas.

(Residence in Baltimore: No. 1001 - W - 36 St. St.; yrs., mos. 2 da.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male. 4-COLOR OR RACE: White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: Feb 12 1913
(Month) (Day) (Year)

7-AGE: 7 yrs. 6 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: — —
(b) General nature of industry, business, or establishment in which employed (or employer): — —

9-BIRTHPLACE (State or Country): Baisikid Mt. -

PARENTS.
10-NAME OF FATHER: Peter Psalidas
11-BIRTHPLACE OF FATHER (State or Country): Greece
12-MAIDEN NAME OF MOTHER: Virginia Tosfill
13-BIRTHPLACE OF MOTHER (State or Country): Greece

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Gus Garaco
(Address) 1001 E. 36th St

15-
Filed AUG 13 1920, 191.....
Robert P. Harrison, Burial Permit Clerk. Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Omission of important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 - 13 - 9 45 A.M. 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Epithelioma Buccal Mucosa
(Duration) yrs. 5 mos. 2 ds.
CONTRIBUTORY (Secondary) Carcinoma
(Duration) yrs. mos. 1 ds.
(Signed) G. Lee Blade M. D.
(Coroner.)
8/31/20 191... (Address) 1431 N. Gay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence Martinsburg W. Va

19-PLACE OF BURIAL OR REMOVAL, Woodlawn — DATE OF BURIAL, Aug. 14, 1920

20-UNDERTAKER Horace Dungee & Son — ADDRESS 3631 Falls Rd.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45683 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45683

45V

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore Gen. St. ..... WARD)

2-FULL NAME Edward Kennet

(a) RESIDENCE. NO. Thames & Broadway ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. + mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) ? 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist. 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant John A Moran (Address) 3000 E Baltost.

15 Filed AUG 13 1920 19 Robert P. Harrison, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1920

17 I HEREBY CERTIFY, That I attended deceased from July 22 1920, to Aug. 12. 1920, that I last saw him alive on Aug 12, 1920, and that death occurred, on the date stated above, at 9.15 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) J. C. Conte Jr., M. D.

, 19 (Address) 1213 Light St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park.	Aug 14 1920

20 UNDERTAKER	ADDRESS
J. A Moran	3000 E. Balto-

CAUSE OF DEATH must be plainly written, and without abbreviations. ATTENTION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.245684

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.245684

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1537 Hanover ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary F. Balla

(Residence in Baltimore: No. 1537 Hanover St.; 59 yrs., 5 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, March (Month) 1 (Day), 1861 (Year)

7-AGE, 59 yrs. 5 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, James Benson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Anna Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F. Balla (Husband)

(Address) 1537 Hanover St.

15-

Filed AUG 14 1920, 191.....

Robert P. Haslett, Registrar.

Burial Permit Clerk

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 11 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1920, to July 11 1920, that I saw her alive on July 11 1920, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Cancer of Liver

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) J. Edw. Kemp M. D.

8/13/20, 192.. (Address) 1 E. Hamilton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem.	Aug. 14..., 1920
20-UNDERTAKER M. J. Flynn	ADDRESS 1432 Light St.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45685 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45685

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 118 Cypress ST.; 25 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Mallonee

(Residence in Baltimore: No. 118 Cypress St.; 51 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH: (Month) (Day) 1869 (Year)

7-AGE 51 yrs. mos. da.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Martin Mallonee

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Lydia Anderson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sallie Mallonee

(Address) 118 Cypress

15- Filed AUG 14 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Aug (Day) 12, (Year) 1920

17-I HEREBY CERTIFY, That I attended deceased from about [illegible] months, that I saw h[illegible] about two weeks, and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(Duration) 8 weeks

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Hastings M. D.

Aug 13, 1920 (Address) 1 Cedar St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill

DATE OF BURIAL, Aug 14, 1920

20-UNDERTAKER John St. Henny

ADDRESS 715 Light St.

IMPORTANT. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45686 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45686

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm A. Green

(a) RESIDENCE. NO. 638 Bruce St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Ohio

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Holten

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mary Green
(Address): 638 N Bruce St

15 Filed AUG 14 1920 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 10 1920

17 I HEREBY CERTIFY, That I attended deceased from July, 1920, to Aug 10th, 1920, that I last saw h— alive on Aug 10, 1920, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency due to Tuberculous Jenitalia.

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary): Hr Prostatis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) J. Zscheuck, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Old Auburn	Aug 14 1920

20 UNDERTAKER JAMES H. DENNIS ADDRESS 1300 PRESTMAN ST

CAUSE OF DEATH must be filled in by PHYSICIAN, if possible. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45687 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45687

CERTIFICATE OF DEATH. 792

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 John ST.: 11 WARD)

2-FULL NAME Sarah Greer Nandain

(a) RESIDENCE. No. 1217 John ST., 11 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~ (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 30-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Dover Del.

PARENTS

10 NAME OF FATHER Elias Nandain

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dover Delaware

12 MAIDEN NAME OF MOTHER Margaret Hitchamp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dover Delaware

14 Informant: Alexander Hardcastle
(Address): 1217 John St.

15 Filed 1920 16 Registered Robert P. Harrison,
Burial Permit Clerk.

AUG 14 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1916, to Aug 13 1920, that I last saw her alive on Aug 12 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Geo M Geaw, M. D.

8/14, 1920 (Address) 20 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Denton Md.

DATE OF BURIAL: 8-14 1920

20 UNDERTAKER: HENRY W. JENKINS & SONS CO.

ADDRESS: MC CULLOH & ORCHARD STS.

CAUSE OF DEATH in plain terms, so that it may be understood. Do not use abbreviations or technical terms. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45688

D45688

CERTIFICATE OF DEATH.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Warren Mt Winans St. 25 WARD)

2-FULL NAME Helen Collins Hughes.

(Residence in Baltimore: No. Warren & Mt Winans St.; 25 yrs., — mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July (Month) 29 (Day), 1895 (Year)

7-AGE, 25 yrs. 11 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James F. Collins

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah Savage

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Collins

(Address) Mt Winans

15- AUG 14 1920, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 12 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 10 1920, to Aug 12 1920,
that I saw her alive on Aug 11 1920,
and that death occurred, on the date stated above, at 12.30 a m.

The CAUSE OF DEATH* was as follows:

Influenza Ca.

(Duration) 1 yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease (Duration) no yrs. 4 mos. — ds.

(Signed) Raymond W. Hagner M. D.

Aug 17, 1920 (Address) Oakland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Aug 14 1920

20-UNDERTAKER John H. Tradine — ADDRESS 1427 Mc Neil St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D.45689

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45689

CERTIFICATE OF DEATH.

REGISTERED No. C 19 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 W. Fayette ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred M. Demuth

(Residence in Baltimore: No. 1701 W. Fayette St.; 13 yrs. 8 mos. 3 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec (Month) 9 (Day), 1906 (Year)

7-AGE, 13 yrs. 8 mos. 3 da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School-girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, William H. Demuth

11-BIRTHPLACE OF FATHER (State or Country), Balto - Md

12-MAIDEN NAME OF MOTHER Hannah Weber

13-BIRTHPLACE OF MOTHER (State or Country), Balto - Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm H. Demuth

(Address) 1701 W. Fayette St.

15-

AUG 14 1920

Filed Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 12 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1919, to Aug 12 1920, that I saw her alive on Aug 12 1920, and that death occurred, on the date stated above, at 2-20 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) Uremia

(Duration) ....yrs. ....mos. ....da.

(Signed) Neva C. Clyde M. D.

Aug 12, 1920 (Address) 1203 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Aug 14, 1920
20-UNDERTAKER	ADDRESS
Jos Joerdens Son	1172 Pac

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.45690 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.45690

CERTIFICATE OF DEATH. 20

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 Locust- ST.: 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lovitak

(a) RESIDENCE. NO. 106 Locust ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem'l | 4 COLOR OR RACE: Wht | 5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7/16

7 AGE: Years 4 | Months 3 | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt

PARENTS

10 NAME OF FATHER John Lovitak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER Anna Zavrony

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant (Address): John Lovitak 106 Locust St

15 Filed AUG 14 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1920

17 I HEREBY CERTIFY, That I attended deceased from July 8th, 1920, to July 13, 1920, that I last saw h[illegible] alive on July 12, 1920, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

General Infection

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Bad Tonsil & Throat

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Gen'l Symptoms

(Signed) H. Kuhlmann, M. D.

19 (Address) 1340 St Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross G.G. | DATE OF BURIAL: July 14 1920

20 UNDERTAKER: Frank Enoch & Son | ADDRESS: 1711 Eutaw

CAUSE OF DEATH in plain terms, so that a correct classification may be made on back of certificates. TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45691 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45691

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1127 Park Ave ST. 11 WARD)

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Bordley

(a) RESIDENCE. No. 1127 Park. Ave. ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col.	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Bordley.

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home - Wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know.

14 Informant Wm H. Johnson

(Address) 604 N. Bethel.

15 Filed Robert P. Harrison, 19 Registrar

AUG 14 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-11-1920

17 I HEREBY CERTIFY, That I attended deceased from 8-10-, 1920, to 8-, 1920, that I last saw her alive on 8-11-, 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cortical Insufficiency

Independent (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cortical Sclerosis Independent. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wyt. Cargill, M. D.

8-12-1920 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Henry Clay	Aug 15 1920
20 UNDERTAKER	ADDRESS
Sam'l R. Chase Son	1400 Madison

CAUSE OF DEATH to be plainly written. Do not use abbreviations or ditto marks. Consult physician if necessary. Carefully read the questions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 45692 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 45692

105

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. Maryland General Hospital ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME M. Ellen Cofr.

(a) RESIDENCE. NO. 2513 E. North Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1st 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) ptl

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph B. Polen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Brad

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant (Address) Ada R. Kettlewell 2513 E. North Ave

15 Filed AUG 14 1920, 19 Robert P. Harrison, Registrar [Burial Permit Clerk]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 13 1920

17 I HEREBY CERTIFY, That I attended deceased from August 9. 1920. to August 13. 1920.; that I last saw h er alive on August 13 1920; and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 7. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? At home.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings.

(Signed) Herbert Stewart, M. D.

8/13. 1920 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	8-16 1920
20 UNDERTAKER	ADDRESS
Graham T. Walker	923 Madison

CAUSE OF DEATH to be filled in plainly. See instructions on back of certificates.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45693

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45693

CERTIFICATE OF DEATH.

104 V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1756 Bank ST.: V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Quinn

(a) RESIDENCE. NO. 1756 Bank ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 4th 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas Quinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Tierney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Anna Tierney
(Address) 1756 Bank St

15 Filed AUG 14 1920 Robert P. Harrison, Registrar
[Burial Permit Clerk]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1920, to Aug 12, 1920, that I last saw h— alive on Aug 12, 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Harrison, M. D.

Aug 13, 1920 (Address) 165 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug 14th 1920

20 UNDERTAKER Millard B Callender ADDRESS 1760 Bank St

CAUSE OF DEATH must be plainly written, and all questions answered so far as possible. Use ink. Do not use lead pencil. Do not write on back of certificates. ATION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45694

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45694

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 S. Kenwood ave St.; 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Daerer

(a) RESIDENCE. NO. 1002 S. Kenwood ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of: None

6 DATE OF BIRTH (month, day, and year) 8/13/20

7 AGE — Years — Months — Days — If LESS than 1 day, ... hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): of

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: John L. Daerer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Carrie Warshaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bargmar

14 Informant: John L Daerer
(Address) 1002 S. Kenwood

15 Filed ... 19... Robert P. Harrison, Registrar

AUG 14 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 13 1920

17 I HEREBY CERTIFY, That I attended deceased from 8 13 1920 to 8 13 1920

that I last saw h~~im~~ alive on 8 13 1920

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Premature Birth
Foetus 6 months

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harvey B Tilton, M. D.

8/13, 1920 (Address) 2921 Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 8/14 1920

20 UNDERTAKER: Stephen J. Fiel Kowski

ADDRESS 1000 S. Kenwood

CAUSE OF DEATH TO BE FILLED IN BY ATTENDING PHYSICIAN. See instruction on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45695

HEALTH DEPARTMENT—CITY OF BALTIMORE

D/45695

151V

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 S. Kenwood Ave ST.; 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Doerer

(a) RESIDENCE. NO. 1002 S. Kenwood ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): 8/13/20

7 AGE — Years — Months — Days — If LESS than 1 day, ... hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John L. Doerer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Marie Warshaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: John Doerer
(Address) 1002 S. Kenwood

15 Filed AUG 14 1920 Robert P. Harrison, Registrar
(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8 13 1920

17 I HEREBY CERTIFY, That I attended deceased from 8 13 1920 to 8 13 1920

that I last saw him alive on 8 13 1920, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Premature Birth

Factus 6 months

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hanaa B. Tilcon M. D.

8/14 1920 (Address) 2922 Adams Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 8/14 1920

20 UNDERTAKER: Stephen J. Fialkowski

ADDRESS: 1002 S. Kenwood

CAUSE OF DEATH MUST BE FILLED IN. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45696

CERTIFICATE OF DEATH.

D45696

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1521 E. Monument ST.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Thompson

(a) RESIDENCE. No. 1521 E. Monument ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Thompson

6 DATE OF BIRTH (month, day, and year) October 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hebrew Home

9 BIRTHPLACE (city or town) (State or country) Westmoreland Co Va

PARENTS

10 NAME OF FATHER Dennis Rawlins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eliza Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Blanche Wright (Address) 1521 E Monument St

15 Filed AUG 14 1920, 19 Robert F. Harvey Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12, 1920

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1920, to Aug. 12, 1920, that I last saw h[illegible] alive on Aug 12, 1920, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus and bowel

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

8/13 19 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Lawn	Aug 14 1920
20 UNDERTAKER Saml F Hemsley	ADDRESS 578 N Bidd

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Borowski

D.45697 HEALTH DEPARTMENT—CITY OF BALTIMORE D45697

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 706 E Baltimore ST. 7 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Stanislaus Borowski

(Residence in Baltimore: No. 706 E Baltimore St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec 25, 1919
(Month) (Day) (Year)

7-AGE, ...yrs. 7 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wladislaus Borowski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Josephine Jankowska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wladislaus Borowski

(Address) 706 E Baltimore St

15-

Filed AUG 14 1920, 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 13, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Acute Dilatation of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Theodore Rudolf Diehl M. D.
(Coroner)

Aug 14, 1920. (Address) 1000 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus — DATE OF BURIAL, August 14, 1920

20-UNDERTAKER John M Weber — ADDRESS 1803 Bank St

N. B.—Every item of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONTRIBUTORY, SECONDARY, and COMPLICATING CAUSES important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

10 45698 HEALTH DEPARTMENT—CITY OF BALTIMORE 10 45698

6. CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1829 Bradle st ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Garcia

(a) RESIDENCE. No. 1829 Bradle ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of .

6 DATE OF BIRTH (month, day, and year) Aug 13/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Garcia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Theresa Henderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Joseph Garcia

(Address) 1829 Bradle st

15 Filed AUG 15, 1920 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1920, to Aug 13, 1920, that I last saw h a alive on Aug 13, 1920, and that death occurred, on the date stated above, at 12 .m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Six mos. pregnancy)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wallis W White Jr. M. D.

8/13, 1920 (Address) 2800 St Paul st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Neurological Laboratory

DATE OF BURIAL 19

20 UNDERTAKER (Phipps)

ADDRESS

HOW IS VERY important. See INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45699 HEALTH DEPARTMENT—CITY OF BALTIMORE D45699

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7000 Ridgewood Ave. St.: 15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Bankard

(a) RESIDENCE. No. 7000 Ridgewood Ave St.: Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno. Bankard

6 DATE OF BIRTH (month, day, and year) Oct 26 - 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md

PARENTS

10 NAME OF FATHER Wm Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Maud Foreman

(Address) 1022 McDonough St

15 Filed AUG 15 1920 ROBERT J. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14 1920

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1920, to Aug. 14th, 1920, that I last saw her alive on Aug. 13 1920, and that death occurred, on the date stated above, at 12 8 m.

The CAUSE OF DEATH* was as follows:

Vascular Dis. of Heart & Dilated Heart

2 or 3 years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination.

(Signed) Ed Smith, M. D.

Aug 14 1920 (Address) 1605 W North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Md	Aug 17 1920
20 UNDERTAKER	ADDRESS
Harry W. Ebert	W. North Ave

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D45700

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46700

CERTIFICATE OF DEATH.

104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 N Patterson Pk Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beatrice Eva Kagan

(Residence in Baltimore: No. 406 N. Patterson Pk Ave St.; 1 yrs., mos. 8 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH. Aug 6, 1919 (Month) (Day) (Year)

7-AGE. 1 yrs. mos. 8 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balt City Md

PARENTS.

10-NAME OF FATHER. Jack Kagan

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Minnie Rosenthal

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis

(Address) 1411 E Balto

15- AUG 15 1920 ROBERT J. KRAUTER

Filed....., 191... Registrar.

CAUSE OF DEATH to be plainly written. Every question must be answered if important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. August 14, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 10 1920, to Aug 14 1920, that I saw h[illegible] alive on Aug 14 1920, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(Duration)..... yrs..... mos. 4 da.

CONTRIBUTORY (Secondary) Rachitis

(Duration)..... yrs..... mos..... da.

(Signed) Frank J Ayd M. D.

Aug 14, 1920 (Address) 2065 E Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Hebrew Friendship Cem

DATE OF BURIAL. Aug 15, 1920

20-UNDERTAKER Jack Louis

ADDRESS 1411 E Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

1045701

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045701

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 251 Harrison St ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pauline Koenigsberg

(Residence in Baltimore: No. 251 Harrison St St.; 5/12 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH. July (Month) 30 (Day) 1904 (Year)

7-AGE. 16 yrs. ..... mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Typist
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balt Md

PARENTS.

10-NAME OF FATHER. Samuel Koenigsberg

11-BIRTHPLACE OF FATHER (State or Country). Hungary

12-MAIDEN NAME OF MOTHER Sadie Markheim

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Leurs

(Address) 1411 E Balto St

15- AUG 15 1920 ROBERT F KRAUTER

Filed....., 191..... Registrar.

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 13th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 29 1920, to Aug 13 1920, that I saw her alive on August 13 1920, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis; Streptococcus Viridans infection; Mitral & aortic insufficiencies (Duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis (myocardial degeneration) (Duration) — yrs. — mos. 7 ds.

(Signed) Louis P. Hamburger M. D.

Aug 14, 1920. (Address) 1207 Eutaw P.L.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Hebrew Friendship Cem

DATE OF BURIAL. 8—15, 1920

20-UNDERTAKER Jack Leurs

ADDRESS 1411 E Balt

Spec.—8-24-14—M. & T.—2000 Blks.

1045702

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045702

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1035 Druid Hill Ave St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wallace Clark

(Residence in Baltimore: No. 1035 Druid Hill Ave St.; 40 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, ... Not known (Month) ..... (Day), 1864 (Year)

7-AGE, 56 yrs. ..... mos. ..... da. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Porter
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), St. Mary's County

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eliza Clark wife

(Address) 1035 Druid Hill

15- AUG 15 1920 Filed ....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1920, to August 12 1920, that I saw h.. alive on August 11 1920, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 4 yrs. 5 mos. 5 da.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... da.

(Signed) E. J. Y Healicot M. D.

(Address) 2 W 39th Hamburg

Aug. 14, 1920

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. | DATE OF BURIAL, Aug. 15, 1920

20-UNDERTAKER George H. Holland | ADDRESS 1631 Druid 16th

Give information important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45703

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45703

CERTIFICATE OF DEATH.

8-104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4043 Hartford Rd. (ST.:) 8 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Franklin O'Kelly

(a) RESIDENCE. NO. 4043 Hartford Rd ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 1 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edward M. O'Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ruth Littlehales

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Edward M. O'Kelly
(Address) 4043 Hartford Rd

15 Filed AUG 15 1920 ROBERT I. LEUTEN Registrar
Social Service Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1920, to Aug 13, 1920, that I last saw him alive on Aug 13, 1920, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
+ Ulcer Colitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pertussis (?)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. Simons, M. D.

1920 (Address) 4706-Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Park Wood	Aug 15 1920
20 UNDERTAKER	ADDRESS
Wm Curtis	3704 Belair

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 45704 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45704

CERTIFICATE OF DEATH. 174

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2003 Druid Hill Ave (St.:) 14 (Ward) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Talbott

(a) RESIDENCE. No. 2003 Druid Hill St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
53				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sister at St Katherine Home

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wesley Talbott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Fresco

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Sister in Charge St Katherine Home 2003 Druid Hill

Filed AUG 15 1920 Registrar ROBERT E KLAUTKE

Talbott 1008 Catherdral Place

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 10 1920 to Aug 14 1920, that I last saw h[er] alive on Aug 14 1920, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Heart prostration

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion Hyperpiesia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Picture

(Signed) Dr Talbott M. D.

, 19 (Address) 1008 Catherdral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Aug 16 1920
20 UNDERTAKER: John O. Mitchell	ADDRESS: 120 W Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

141 781 / 245705

HEALTH DEPARTMENT—CITY OF BALTIMORE

245705

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 409 N. Duncan St. ST.; 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Albers.

(a) RESIDENCE. NO. 615 S. Montford Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Albers

6 DATE OF BIRTH (month, day, and year) Sept 8, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Charles Horky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Hannah Bruce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record

(Address) Johns Hopkins Hosp.

15 Filed AUG 15 1920 19 ROBERT J. HAGER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1920

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1920, to Aug 13, 1920, that I last saw her alive on August 13, 1920, and that death occurred, on the date stated above, at 4. a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phthalein. Blood urea

(Signed) [illegible] M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 16 1920
20 UNDERTAKER	ADDRESS
Frank Enoch & Son	1906 Eutaw St.

CAUSE OF DEATH in plain terms, so that a correct classification may be made. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045706 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045706

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2111 Ashland Ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wenceslaus Melichar

(a) RESIDENCE. NO. 2111 Ashland Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? 15 yrs. 5 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 18-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Catholic Priest

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Klatovy-Bohemia

PARENTS

10 NAME OF FATHER Wenceslaus Melichar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Jos. Gatt
(Address) 2111 Ashland Ave

15 AUG 15 1920 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1920

17 I HEREBY CERTIFY, That I attended deceased from September-2. 1919. to August-13. 1920. that I last saw him alive on August-13. 1920. and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation -
Angina Pectoris
(duration) yrs. mos. 1/4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (senile)
(duration) 3 yrs. 11 mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) William F. Schwartz M. D.
Aug. 14. 1920 (Address) 1200 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 16 1920
20 UNDERTAKER	ADDRESS
Frank Enoch Son	1906 Ashland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045707 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045707

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Lee

(a) RESIDENCE. No. 2816 Simpson St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Mullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed AUG 15 1920 19 ROBERT I. GRIFFITH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 13, 1920

17

I HEREBY CERTIFY, That I attended deceased from August 4, 1920, to August 13 1920.

that I last saw her alive on August 13, 1920.

and that death occurred, on the date stated above, at 9:50 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis with hypertension

(duration) ? yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? No especial test

(Signed) [illegible] M. D.

8/13/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Zion Bap. Ground DATE OF BURIAL Aug 15 1920

20 UNDERTAKER [illegible] ADDRESS 578 W Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45708 HEALTH DEPARTMENT—CITY OF BALTIMORE D45708

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. St.: 6 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Zimler

(a) RESIDENCE. No. 1915 Orleans St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 8/13/20

7 AGE Years Months Days If LESS than 1 day, 6 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Zimler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ethel Schore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Joseph Zimler 1918 Orleans

15 Filed AUG 15 1920 [illegible] Registrar

Burial Permit Giv[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1920

17

I HEREBY CERTIFY, That I attended deceased from 8/13, 1920, to 8/13, 1920, that I last saw him alive on 8/13, 1920, and that death occurred, on the date stated above, at 9.40 p. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Simon D. Ridgely, M. D.

8/15 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt. Carmel	Aug. 15 1920

20 UNDERTAKER M. J. Kevenson ADDRESS 1[illegible] E. Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045709 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045709

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 828 N. Chester, ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Gebelein

(a) RESIDENCE. No. 828 N. Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of George Gebelein

6 DATE OF BIRTH (month, day, and year) March 7th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co Md

PARENTS

10 NAME OF FATHER John Lehnéis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Vogel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Gebelein
(Address) 828 N. Chester st

15 AUG 15 1920 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1920, to Aug 13, 1920, that I last saw her alive on Aug 13, 1920, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus

(duration) 2? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of April 19/20

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Alan B Lemmon M. D.

8/13/20 (Address) 718 N. Pallerson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Aug 16th 1920
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificates.

1045710 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045710

CERTIFICATE OF DEATH. 138

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 425 Fawn ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Bivona

(Residence in Baltimore: No. 425 Fawn St. (yrs. 14) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.) Married.

6-DATE OF BIRTH, Sept. 15th, 1895
(Month) (Day) (Year)

7-AGE, 24 yrs. 10 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Pietro Cisola

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rosonia Scagalle

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pietro Bivona

(Address) 773-N. Forest St

15- Filed AUG 15 1920, 191.. ROBERT F. ELLIOTT Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 12, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Puerperal Albuminuria

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Guilfoy M. D.
(Coroner)

, 191... (Address) 4 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Vincent Cem — DATE OF BURIAL, Aug. 15, 1920.

20-UNDERTAKER George J. Puth — ADDRESS 1735 Aisquith ave.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Mildred Hawkins

1045711 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045711

184

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 628 Penlucan St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Hawkins,

(Residence in Baltimore: No. 628 Penlucan St.) (yrs. 19 mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Female	Col.	Single

6-DATE OF BIRTH, ..., 1894
(Month) (Day) (Year)

7-AGE, 26 yrs. — mos. — da. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), N C

PARENTS.

10-NAME OF FATHER, Julius Crow

11-BIRTHPLACE OF FATHER (State or Country). N C

12-MAIDEN NAME OF MOTHER Jane Miller

13-BIRTHPLACE OF MOTHER (State or Country), N C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Jane Crow

(Address) 1404 Orleans St

15- AUG 15 1920 ROBERT J. SLAUTER
Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 10, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide. Julius Howell by some unknown unknown.

(Duration) ....yrs....mos....da.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....da.

(Signed) J. Knot Donley M. D.
(Coroner.)

8-14 1920 (Address) Cen. N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Leakin Cemetery	Aug 13 1920
20-UNDERTAKER	ADDRESS 1725
Mrs Robt Arthur	Aisquith

N. B.—Every item of information should be carefully supplied. AGE should be carefully calculated, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1045712 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045712

CERTIFICATE OF DEATH. 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 Edmondson St.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Blackwell

(a) RESIDENCE. No. 211 Edmondson WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fmale

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emory Blackwell

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE: Years 36 yrs | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Hyattsville

PARENTS

10 NAME OF FATHER: Ruffin Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country): South Carolina

12 MAIDEN NAME OF MOTHER: Jane Inman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Emory Blackwell (Address) 211 Edmondson St.

15 Filed: AUG 15 1920 [illegible] Registrar Social Service Dept.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1920, to Aug 13, 1920, that I last saw h[illegible] alive on Aug 13, 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows: Primary Tuberculosis

2

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Fecal Impaction Strangulated Hernia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr Thos Kaelin M. D.

Aug 14 1920 (Address) 3450 Fuelton a

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hyattsville Md — DATE OF BURIAL: Aug 16 1920

20 UNDERTAKER: Edw. W. Pyle — ADDRESS 900 Edmondson Ave

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

945-713

HEALTH DEPARTMENT—CITY OF BALTIMORE

945-713

CERTIFICATE OF DEATH.

× 40

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1229 McCulloh ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lou G Edwards

(a) RESIDENCE. No. 1229 McCulloh ST., WARD. Ohio

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Evan O Edwards

6 DATE OF BIRTH (month, day, and year) May 22 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Alfred Donard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Jane Driskell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Evan O Edwards

(Address) 1229 McCulloh

15 Filed AUG 15 1920 19 ... Burial Permit ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 14 1920

17 I HEREBY CERTIFY, That I attended deceased from August, 1917, to August 14, 1920, that I last saw her alive on August 13, 1920, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Slavonic Mutual

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Pathological Specimen

(Signed) Jerry M Little M. D.

Aug 14 1920 (Address) 724 E Mary Land Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oberlin Ohio	Aug 15 1920
20 UNDERTAKER	ADDRESS
W Maurice Rountree	230 N Green

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

2045714

HEALTH DEPARTMENT—CITY OF BALTIMORE

2045714

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 916 (St.) S. Paca St. (Ward) 21

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jno. F. Jones.

(a) RESIDENCE. NO. 916 S. Paca ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life time mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Agnes Jones.

6 DATE OF BIRTH (month, day, and year): Apr. 23-1865

7 AGE: Years 55 Months 3 Days 21 If LESS than 1 day, hrs. or mln.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman

(b) General nature of industry, business, or establishment in which employed (or employer): Steamboat.

(c) Name of employer: Ney & Lay.

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Jno. Jones.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Rhode Island.

12 MAIDEN NAME OF MOTHER: Mary O'Melia

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant (Address): Grace Jones. 916 S. Paca St.

15 Filed AUG 15 1920 [illegible] Registrar

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 13 1920. to Aug 13 1920.

that I last saw him alive on Aug 13 1920.

and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) 1 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) 1 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —.

Was there an autopsy? No —

What test confirmed diagnosis? Clinical.

(Signed) H. G. Hitchings, M. D.

Aug. 19 20 (Address) 842 Cathedral.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery. DATE OF BURIAL: Aug 16 1920

20 UNDERTAKER: H. S. Deguara & Son ADDRESS 1600 S. Paca

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045715 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045715

CERTIFICATE OF DEATH. 42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes' Hospital (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Veronica Dembach

(a) RESIDENCE. No. 628 Kenwood Ave. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	M

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Dembach

6 DATE OF BIRTH (month, day, and year) April 12 - 1890

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. ... min.
	30	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frank Yabel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Pauline Valenka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Mrs. Frank Dembach

(Address) 628 Kenwood Ave

15 AUG 15 1920 Registrar

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 6, 1920, to Aug 14, 1920, that I last saw h.e alive on Aug 14, 1920, and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Cancer (chorio-epithelioma).

(duration) 0 yrs. 7 mos. 14 ds.

CONTRIBUTORY (Secondary) Operation.

(Haemorrhage?) (duration) yrs. mos. 1 da

18 Where was disease contracted if not at place of death? Do not know.

Did an operation precede death? Yes Date of 8-14-20.

Was there an autopsy? Partial.

What test confirmed diagnosis? Microscopic.

(Signed) Dudley P. Bowe M. D.

8-14-20 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether (Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Aug 17 1920
20 UNDERTAKER	ADDRESS
Wm Fairfowl	1618 Eastern

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45716

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45716

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 408. S. Collington ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wanda L. Lupayko

(a) RESIDENCE. NO. 408. S. Collington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Wht	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Lupayko

11 BIRTHPLACE OF FATHER (city or town) (State or country) austria

12 MAIDEN NAME OF MOTHER Elizabeth Kostowicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Lupayko
(Address) 408. S. Collington

15 Filed AUG 15 1920 ROBT. ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1920, to Aug 14, 1920, that I last saw h.r alive on Aug 14, 1920, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Wentzen, M. D.

Aug 15, 1920 (Address) 165 Bailey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Aug 16 1920
20 UNDERTAKER	ADDRESS
Jos Falkowski	164 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. PARTICULAR ATTENTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

045717 HEALTH DEPARTMENT—CITY OF BALTIMORE 045717

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 602 S. Kenwood Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F. J. Schehlein

(a) RESIDENCE. NO. 602 S. Kenwood Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Schehlein

6 DATE OF BIRTH (month, day, and year) Oct 14-1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pressman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Felix Agnus & Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. J. Schehlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Eliz. Baumschmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna M. Schehlein

(Address) 602 S. Kenwood Ave

15 Filed AUG 15 1920 [illegible] Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1920

17 I HEREBY CERTIFY, That I attended deceased from July 4th, 1920, to Aug 13th, 1920, that I last saw him alive on Aug 13th, 1920, and that death occurred, on the date stated above, at 5:15 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Typhoid Fever

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? American Bldg

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Widal Test

(Signed) John Albert Miller, M. D.

, 19 (Address) 2739 Eastern Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	Aug 16 1920
20 UNDERTAKER	ADDRESS
Zirkler & Zirkler	1739 E. Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. PHYSICIANS should be careful to see that all information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION may be properly classified. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045718 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045718

50

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1429 Eastern Ave ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard P. Andrews

(a) RESIDENCE. NO. 1429 Eastern Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 16, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Pool room & retail tobacco.

(c) Name of employer do

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Richard Andrews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Brochard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Miss Andrews

(Address) 1429 Eastern Ave

15 Aug 15 1920 19 ROBERT F. PRUTTE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1920, to Aug 13, 1920, that I last saw h.. alive on Aug 13, 1920, and that death occurred, on the date stated above, at 1145 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

several years
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) exhaustion + gangrene of foot.
(duration) + yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) D.W. Jones M.D. (for W.H. Wright M. D.)

Address 1093 S. Eutaw Ave.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bath Cemetery — DATE OF BURIAL: Aug 16 1920

20 UNDERTAKER: Kendall Dryfoos & Son — ADDRESS: 373 Mn

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks. Inf of Michael + Johanna Grande.

L45719

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 | 5 | REGISTERED No. C L45719

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 S. Potomac ST.; 1 WARD)

2-FULL NAME None given (5 months miscarriage)

(Residence in Baltimore: No. 528 S. Potomac St.; ...yrs., ...mos. 7 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, Aug 14, 1920 (Month) (Day) (Year)

7-AGE, ...yrs...mos...ds. If LESS than 1 day, 3 ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Michael Grande

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Johanna Del Sordo

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Johanna Grande

(Address) 528 S. Potomac St

15- AUG 15 1920 Filed ..., 191... ROBERT P. BEAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 14, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 14 1920, to Aug 14 1920, that I saw her alive on Aug 14 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

(a) Five months miscarriage

(Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs...mos...ds.

(Signed) Eugene L Penna M. D.

Aug. 15, 1920 (Address) 2314 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Agnes	Aug 16, 1920
20-UNDERTAKER	ADDRESS
Martin W E Dippel	37 Hanover St

CAUSE OF DEATH in plain terms, as much as may be important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

Loudenslager

145720

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164 145720

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3843 Frees Road ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Elva Loudenslager.

(a) RESIDENCE. No. 3843 Frees Road ST.: 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 9 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 30, 1906

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
13	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward C Loudenslager

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Garrison Carey

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant Edward C Loudenslager

(Address) 3843 Frees Road

15 Filed AUG 15 1920 COPIED BY [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 13 4.30 P.M. 1920, to Aug 13, 20 8 P.M. 19

that I last saw h[illegible] alive on Aug 13, 20 6.4 P.M. 19

and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia following Acute Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. B. Nourse, M. D.

Aug 13, 1920 (Address) 854 Cleveland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft. Marys Hampden	Aug 16 '20
20 UNDERTAKER	ADDRESS
Horace Burgee Sons	63 Fallsway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1045721 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045721

CERTIFICATE OF DEATH.

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1374 N. Carey ST.: 15 WARD)

2-FULL NAME Bessie Lomas

(Residence in Baltimore: No. 1374 N. Carey St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 24 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, February 4, 1879 (Month) (Day) (Year)

7-AGE, 41 yrs. 6 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Home Duties
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) West Virginia

PARENTS.

10-NAME OF FATHER, Richard Morris

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Emma Hunter

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Lomas

(Address) 1374 N. Carey St.

15- Filed AUG 15 1920 191... Burial Permit Obtd. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 14, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) No history

(Duration) yrs. mos. ds.

(Signed) J. E. Hennessy M. D. (Coroner.)

August 14 1920 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Aug 18 1920

20-UNDERTAKER Edw. Quiggold

ADDRESS 1463 Carey

N. B.—Every item of information should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1045722 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045722

CERTIFICATE OF DEATH.

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1704 Pressman ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Thompson

(Residence in Baltimore: No. 1704 Pressman St St.; yrs., mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	black	single

6-DATE OF BIRTH, July (Month) 31 (Day), 1920 (Year)

7-AGE, ...yrs. ....mos. 14 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant (none)
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James Thompson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Susan Grey

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susan Thompson

(Address) 1704 Pressman St.

15- Filed AUG 15 1920, 191.... ROBERT I. LITTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 13 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Entero-colitis

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. D. Hennessy M. D. (Coroner.)

August 14 1920 (Address) 2802 Edmondson Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Aug 15. 1920

20-UNDERTAKER, Edw. Kinggold — ADDRESS 1463 Carey St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

045723 HEALTH DEPARTMENT—CITY OF BALTIMORE 045723

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1439 N. Mount St. 15 WARD)

REGISTERED No. C 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Stepney

(Residence in Baltimore: No. 1439 N. Mount St.? yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, August 10, 1881
(Month) (Day) (Year)

7-AGE, 39 yrs. mos. 2 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Huckster (vegetables)
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Alex Stepney

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Esther Griffin

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. James Stepney

(Address) 1439 N. Mount St

15- Filed AUG 15 1920, 191 ROBERT I KLEUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

August 12 1920 (Address) 2602 Edmonson Ave

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, [redacted] DATE OF BURIAL, Aug. 15, 1920

20-UNDERTAKER Edw. Ruggold ADDRESS 1463 Maryland

N. B.—Every item of information should be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

Brzostek

L45724

HEALTH DEPARTMENT—CITY OF BALTIMORE

L45724

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 Aliceanna St.; 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Czeslaw Brzostek

(a) RESIDENCE. No. 1903 Aliceanna ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 40

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Antoni Brzostek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Jasiulowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Anthoni Brzostek

(Address) 1903 Bank St

15 FILED AUG 15 1920 BOARD OF HEALTH Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1920, to Aug 14, 1920, that I last saw him alive on Aug 14, 1920, and that death occurred, on the date stated above, at 255 A m.

The CAUSE OF DEATH* was as follows:

Summer Diarrhoea

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) Dr. Seymour, M. D.

8/16/20 (Address) 2528 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	August 16 1920

20 UNDERTAKER John M. Weber ADDRESS 1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

045725 HEALTH DEPARTMENT—CITY OF BALTIMORE 045725

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 3510 Belair Road St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doris Langley

(Residence in Baltimore: No. 3510 Belair Road St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, July 14, 1920 (Month) (Day) (Year)

7-AGE, ... yrs. 6 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James A Langley

11-BIRTHPLACE OF FATHER (State or Country) Baltimore

12-MAIDEN NAME OF MOTHER Elizabeth Smith

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Langley

(Address) 1763 N. Gay St.

15- Filed AUG 16 1920, 191..... ROBERT E KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 14, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 7 1920, to August 14 1920, that I saw her alive on August 13 1920, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Adolph C. Eisenbrey M. D.

Aug. 15, 1920 (Address) 2201 Orleans St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery — DATE OF BURIAL, Aug. 17, 1920

20-UNDERTAKER J Herwig & Co — ADDRESS 2008 Eleanor

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045726

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045726

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 Nilsen Ave ST.; 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Fillinger

(a) RESIDENCE. NO. 1907 Nilsen Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John C. Fillinger

6 DATE OF BIRTH (month, day, and year): Aug 15-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Davis Ritter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md

12 MAIDEN NAME OF MOTHER: Elizabeth Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Emma Heller 1907 Nilsen Ave

15 Filed AUG 16 1920 19 ROBERT F. LEIDIG Registrar Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 14 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920 to Aug 14, 1920; that I last saw h.... alive on Aug 14, 1920; and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 6 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Geo. S. McKeffrey M. D.

Aug 15 1920 (Address) Roxeele Parkend,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 16 1920

20 UNDERTAKER: F. B. Hepfert ADDRESS 2236 Fredk Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Widower

HEALTH DEPARTMENT—CITY OF BALTIMORE

2045727 — 2045727

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 131 Church Ave ST.: Violetville WARD)

REGISTERED NO. 135

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Widmyer

(a) RESIDENCE. NO. 131 Church Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs — mos. — ds. How long in U. S., if of foreign birth? — yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~(husband)~~ (or) WIFE of John Widmyer

6 DATE OF BIRTH (month, day, and year) Nov 15-1895

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo Bateman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Cath Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Catherine Bateman
(Address) 131 Church Ave

15 Filed AUG 16 1920 ROBERT I. BAUER Registrar
Social Service Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14 1920.

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1920, to Aug 14, 1920, that I last saw her alive on Aug 14, 1920, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Lost Pork
Hemorrhage

(duration) 3 hrs. yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Hemorrhage

(Signed) W. A Knell, M. D.

8/16, 1920 (Address) Irvington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

New Cathedral Cemetery Aug 16 1920

20 UNDERTAKER — ADDRESS

F. B. Keppler 2236 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

045728 HEALTH DEPARTMENT—CITY OF BALTIMORE 045728

Nickel

CERTIFICATE OF DEATH. 20

1-PLACE OF DEATH Church Home & Infirmary REGISTERED NO. C.....

CITY OF BALTIMORE: (No.) ..... ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Dickie

(Residence in Baltimore: No. 1907 Elwood Place St.; 2 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct 12, 1897 (Month) (Day) (Year)

7-AGE, 22 yrs. 10 mos. 2 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Benjamin Howard

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs H. Nickel

(Address) 1907 Elwood Place

15- AUG 16 1920 ROBERT L. KNAUER
Filed ....., 191.... DEPUTY
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 14 - 20, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 17 1920, to Aug. 14 1920, that I saw h[er] alive on Aug 14th 1920, and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:
Strep. to coccus Viridans
sept. Femia, 30

(Duration) ..... yrs. ..... mos. 28 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. D. Noble M. D.

Aug 14, 1920 (Address) Church Home Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 28 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Here

Former or usual residence 1907 Elwood Place

19-PLACE OF BURIAL OR REMOVAL, Baltimore | DATE OF BURIAL, Aug. 18 1920

20-UNDERTAKER Wm Cook | ADDRESS 508 E North

CAUSE OF DEATH in plain terms, so that it may be understood by all. Omissions are important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045729

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045729

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. 45-28

CITY OF BALTIMORE: (No Municipal Tuberculosis Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William N. Allender,

(a) RESIDENCE No. 1529 Friendsbury St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 24th, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Allender

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Whitcomb.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records.
(Address)

15 Filed AUG 16 1920 Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 14, 1920

17

I HEREBY CERTIFY, That I attended deceased from July 23rd, 1920, to August 13th, 1920

that I last saw him alive on August 13th, 1920.

And that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemmorrhage.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis?

(Signed) L. J. Digney, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Reistertown Cemetery — DATE OF BURIAL: Aug 17 1920

20 UNDERTAKER: William Cook — ADDRESS: 501 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

H J Evans Grey + Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045730

CERTIFICATE OF DEATH.

120 1045730

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1327 Edmondson Ave ST.; 19 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas William Hall

(a) RESIDENCE. No. 1327 Edmondson Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Violetta Hall

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Basil D Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Danilan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S C.

14 Informant Tyler Hall
(Address) 1327 Edmondson Ave

15 Filed AUG 16 1920 19 ROBERT B. IRATER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb 1920, 19..., to Aug 15, 1920, that I last saw h.. alive on Aug 14, 1920, and that death occurred, on the date stated above, at 3-30 A.m.

The CAUSE OF DEATH* was as follows:

Uraemic Convulsions

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Microscope

(Signed) John A Crabs M. D.

. 19 (Address) 101 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilbur ville Md	Aug 17 1920
20 UNDERTAKER	ADDRESS
H M Cole	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Czezewszkis

D45731

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45731

28

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 534 S Paca St. St.: W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Asierauskis

(a) RESIDENCE. No. 534 S. Paca St. Baltimore St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., If of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
34	—			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Employed

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania.

PARENTS

10 NAME OF FATHER John Asierskis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER G. Mozgute

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Eva Olesinski
(Address) 529 Columbia ave.

15 Filed AUG 16 1920 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 14 August 1920

17

I HEREBY CERTIFY, That I attended deceased from 28 June, 1920, to 13 & August, 1920.

that I last saw h[illegible] alive on 13 & August, 1920.

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis.

Antecedents (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jos. Abramaitis, M. D.

, 19 (Address) 604 S. Paca St. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 16 1920

20 UNDERTAKER — ADDRESS

John Grebliunokas — 425 S. Paca St.

BURIAL PERMIT ISSUED

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L045732 HEALTH DEPARTMENT—CITY OF BALTIMORE L045732

CERTIFICATE OF DEATH. 151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 E Monument St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elon Webb

(a) RESIDENCE. No. 1225 E monument ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. 4 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Alonzo Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Nina Brenton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Nina Brenton
(Address) 1225 E monument St

15 Filed AUG 16 1920 ROBERT J. KRAMER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 8 1920 to Aug 15 1920 that I last saw h alive on Aug 14 1920 and that death occurred, on the date stated above, at 6 am m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Lipe Congenital Debility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? 0 Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward Fisher M. D.

8/16 1920 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	aug 16 1920
20 UNDERTAKER	ADDRESS
Milton Davis	413 N Eden St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045733 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045733

CERTIFICATE OF DEATH. 42

1-PLACE OF DEATH Bredler Sellman Adm REGISTERED NO.

CITY OF BALTIMORE: (No. 2714 N. Charles ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Flora Hopkins McFall

(a) RESIDENCE. No. 4001 Forest Park Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Jasper D. McFall

6 DATE OF BIRTH (month, day, and year): May 6-1856

7 AGE: Years 64 Months 3 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Flora Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: Mrs. P. L. Kaye

(Address): 4001 Forest Park Ave

15 Filed ....., 19 .....

AUG 16 1920

ROBERT I. FRAZIER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 5 1920, to Aug 13 1920, that I last saw her alive on Aug 12 1920, and that death occurred, on the date stated above, at 4.20 P m.

The CAUSE OF DEATH* was as follows:

Uterine carcinoma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) P. R. Kaye, M. D.

. 19 (Address) 6192 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: Aug 16 1920

20 UNDERTAKER: Wm J Tickner & Sons

ADDRESS: N Y Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1045734

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 1045734

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 E. Monument ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret V. King

(a) RESIDENCE. NO. 1617 E. Monument ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 5 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Sam'l. R. King

6 DATE OF BIRTH (month, day, and year) Feb 17 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER James M. Werner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry W. King

(Address) 1617 E. Monument

15 Filed AUG 16 1920 ROBERT F. LEACH Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1920

17 I HEREBY CERTIFY, That I attended deceased from May 10th, 1916. to August 13th 1920. that I last saw her alive on August 13th, 1920. and that death occurred, on the date stated above, at 2 05 p. m.

The CAUSE OF DEATH* was as follows:

Arterio-Solerosis

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) — yrs. — mos. 28 ds.

18 Where was disease contracted if not at place of death? * * * *

Did an operation precede death? no Date of * * *

Was there an autopsy? no

What test confirmed diagnosis? physical examination

(Signed) Edw. M. Singwald, M. D.

7/14 1920 (Address) 5 N. Washington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Aug 16 1920
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Arbans

MATION should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045735 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045735

CERTIFICATE OF DEATH. 104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1735 E. Pratt ST.; W WARD)

2-FULL NAME George M. Zahner

(a) RESIDENCE. NO. 1735 E Pratt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER John Zahner

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Ruth Roth

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant John Zahner
(Address) 1735 E Pratt St

15 Filed AUG 16 1920 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1920, to Aug 14, 1920, that I last saw him alive on Aug 14, 1920, and that death occurred, on the date stated above, at 4.20 a.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-enteritis

(duration) yrs. 11 mos. 9 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Alfred A. Bendrick, M. D.

, 19 (Address) 1228 S. Patterson Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross (Harford Rd)	Aug 16 1920
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Fleet St

mation should be carefully supplied. Any [illegible] it may be properly classified. Exact statement of cause of DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045736 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045736

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 Ryan Lt. ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Burns

(a) RESIDENCE. No. 913 Ryan ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: male white

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year) June 15 1st 1920.

7 AGE — Years: — Months: 2 — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of Industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Wm S Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Annie S Chipman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs Wm S Burns (Address) 913 Ryan St.

15 Filed AUG 16 1920 19 ROBERT A. LEACH Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/15 1920

17 I HEREBY CERTIFY, That I attended deceased from 8/14, 1920, to 8/15, 1920.

that I last saw him alive on Aug. 15, 1920,

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) yrs. 7 mos. 10 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) J. Thaon Boyton, M. D.

19 (Address) 888 N. Loudon St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cem. DATE OF BURIAL: Aug 16 1920

20 UNDERTAKER: John J Howard & Son ADDRESS: Govans Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... mation should be carefully supplied. Also, should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Stocksdale

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045737

120 ✓ 1045737

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 W Mulberry St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances S Stocksdale

(Residence in Baltimore: No. 1510 W Mulberry St.; ..... yrs., 4 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, ... Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
75 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None .....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, John B Ray

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Susana Botfield

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stella S. Dean

(Address) 1510 W. Mulberry St

15- AUG 16 1920 RECEIVED REGISTERED

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug. 14 ....., 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Aug 14 1920, that I saw h[illegible] alive on Aug 14 1920, and that death occurred, on the date stated above, at 11 15 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Senile Gen

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis (Chron)

..... (Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Edward Fellows M. D.

Aug 17, 1920 (Address) 2042 St. Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Aug. 17 1920
20-UNDERTAKER Geo J Smith	ADDRESS 1000 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45738 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045738

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore Hospital

CITY OF BALTIMORE: (No. 1213 Light ST. 24 WARD)

REGISTERED NO. 45

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME E. Virginia Welton

(a) RESIDENCE. NO. 122 E. Hamburg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Ind

PARENTS

10 NAME OF FATHER Howard A. White

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Ind

12 MAIDEN NAME OF MOTHER Ella M Berry

13 BIRTHPLACE OF MOTHER (city or town) Charles Co
(State or country) Md

14 Informant Howard A White
(Address) 122 E Hamburg St

15 Filed AUG 16 1920 Emery J Trauter
Registrar
Social Purity Dept

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1920

17 I HEREBY CERTIFY, That I attended deceased from 8-11- , 1920, to 8-16 , 1920, that I last saw her alive on 8-16- , 1920, and that death occurred, on the date stated above, at 12.10 a m.

The CAUSE OF DEATH* was as follows:

Sarcoma of left kidney.

(duration) ? yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 13 - 1920

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Ponte Jr. M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: CEDAR HILL

DATE OF BURIAL: Aug 18 1920

20 UNDERTAKER: JOHN F. DENNY

ADDRESS: 715 LIGHT ST.

mation should be carefully supplied. AGE and
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2045739 2045739

CERTIFICATE OF DEATH.

104

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 931 Bevan st. ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Britton.

(Residence in Baltimore: No. 931 Bevan st. St.; ....yrs., ...mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June 17/20., 1 (Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 27 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto.Md.

PARENTS.

10-NAME OF FATHER, Nestor Britton

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Annie Kuskoko

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nestor Britton

(Address) 931 E. Bevan st.

15- Filed AUG 16 1920, 191.... ROBERT B KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug.15/20., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug.2/20 191, to Aug.16/20. 191, that I saw him alive on Aug.15/20. 191, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-enteritis.

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry Kaercher M. D.

Aug.16/20. (Address) 933 Hanover st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross A.A.Co. DATE OF BURIAL, AUG 16 1920, 191...

20-UNDERTAKER JOHN F. DENNY ADDRESS 715 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45740 HEALTH DEPARTMENT—CITY OF BALTIMORE D45740

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Henning.

(a) RESIDENCE. No. 1107 Battery Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 9th.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Genl. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant City Hospital Records.
(Address)

15 Filed AUG 16 1920 ROBERT E. LEE [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13th, 1920

17 I HEREBY CERTIFY, That I attended deceased from May 11th, 1920, to Aug. 13th, 1920, that I last saw him alive on Aug. 13th, 1920, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) V. B. Hartman, M. D.

, 19 (Address) City Hospital, Roxy Vie

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL CEDAR HILL

DATE OF BURIAL AUG 16 1920

20 UNDERTAKER JOHN F. DENNY

ADDRESS 715 LIGHT ST.

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045741

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045741

CERTIFICATE OF DEATH.

120

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST. 106 WARD)

2-FULL NAME Mr. Francis Mc Grann

(a) RESIDENCE. No. 606 E. Eager Street WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): June 12, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40 yrs.	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manager Joseph F. Kelly.

(b) General nature of industry, business, or establishment in which employed (or employer): Club

(c) Name of employer: Joseph F. Kelly 086

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Francis McGrann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Donoghue

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Wm. B. McGrann.
(Address) 606 E. Eager Street

15 Filed AUG 16 1920 ROBERT P. BRAUTIGAM Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 15 1920

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1920, to Aug 15, 1920
that I last saw him alive on Aug 15, 1920,
and that death occurred, on the date stated above, at 12:01 m.
The CAUSE OF DEATH* was as follows:
Chr. Nephritis - Chr. Uremia

(duration) 4 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) ... yrs. ... mos. 4½ ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 8/15/20

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory

(Signed) W. C. Caldwell, M. D.

. 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Aug 18 1920
20 UNDERTAKER	ADDRESS
H. C. Wadefield	914 Fremont Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S name
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D45742

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45742

CERTIFICATE OF DEATH.

170

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2438 Md ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles F Bartz

(Residence in Baltimore: No. 2438 ~~W. Pr~~ Maryland ave St.; 67 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Dec 17, 1852 (Month) (Day) (Year)

7-AGE, 67 yrs. 7 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Book keeper
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, David Bartz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dora Schlank

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Ethis Bartz

(Address) 20 1 Wheeler ave

15- AUG 16 1920 Filed....., 191. ROBERT F HEATER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 15th, 1920. (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from August 1st 1920, to August 15th 1920, that I saw h in alive on August 15th 1920, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) ..... yrs. ..... mos. .....

CONTRIBUTORY (Secondary) Chronic Interstitial nephritis

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) Geo W Stone M. D.

August 17, 1920 (Address) 1431 Maryland Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem

DATE OF BURIAL, Aug 17, 1920.

20-UNDERTAKER W M Routson

ADDRESS 2238 W North ave

N. B.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

045743 HEALTH DEPARTMENT—CITY OF BALTIMORE 045743

CERTIFICATE OF DEATH. 15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 S. Vincent ST.; 19 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph O'Neill

(Residence in Baltimore: No. 409 S Vincent St.; ....yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, August 14, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), 409 S. Vincent St

PARENTS.

10-NAME OF FATHER, Harry J O'Neill

11-BIRTHPLACE OF FATHER (State or Country), N Y

12-MAIDEN NAME OF MOTHER Theresa Keith

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry J. O'Neill

(Address) 409 S. Vincent

15- Filed AUG 16 1920, 191... ROBERT F. BRAUER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 14 19.., to Aug 14 19.., that I saw h.. alive on Aug 14 19.., and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Edward Rosenbaum M. D.

8/16/20, 191... (Address) 24 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Aug 18, 1920

20-UNDERTAKER Harry A Weitz & Co — ADDRESS 531 W Lombard

N. B.—Every item of information must be given if possible. Cause of death may be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

2045744

HEALTH DEPARTMENT—CITY OF BALTIMORE

2045744

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 W. Mulberry St. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margurette Witherspoon

(a) RESIDENCE. NO. 1611 W. Mulberry St. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 16 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Whiterdpoon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sumpter S.C.

12 MAIDEN NAME OF MOTHER Amelia Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) King and Queen Co. Va.

14 Informant John Whiterspoon

(Address) 16[illegible] W. Mulberry St.

15 AUG 16 1920 ROBERT A. [illegible] Registrar

Serial No. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 14 Aug. 1920 19

17 I HEREBY CERTIFY, That I attended deceased from 11 August 1920, to 14 Aug. 1920 19, that I last saw her alive on 14 Aug 1920, 19, and that death occurred, on the date stated above, at 5. p. m.

The CAUSE OF DEATH* was as follows:

Gangrenous Stomatitis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physcal Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL Aug 16th 1920

20 UNDERTAKER Samuel T. Hensley ADDRESS 978 N. Bridle

N. B. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1045745

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045745

104

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 927 Fell ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Grill Jr.

(Residence in Baltimore: No. 927 Fell St.; ....yrs. 16 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April 2nd (Month) (Day), 1918 (Year)

7-AGE, 1 yrs. 4 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John A Grill

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Josephine Chada

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josephine Grill

(Address) 927 Fell St.

15-

Filed AUG 16 1920 ..... Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 13 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 11 1920, to Aug 13 1920, that I saw him alive on Aug 12 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Enteritis - Colitis

(Duration) ....yrs. ....mos. 32 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Les Fellers M. D.

8-17, 1920 (Address) 1937 Douglas Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Aug. 16., 1920

20-UNDERTAKER Hilliard & Callender — ADDRESS 1760 Bank

N. B. BURIAL OR REMOVAL PERMIT WILL NOT BE ISSUED UNLESS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045-746 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045-746

CERTIFICATE OF DEATH. 28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 N Milton Ave ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine M. Strickling

(a) RESIDENCE. No. 525 N Milton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Widowed

5a If married, widowed, or divorced (or) WIFE of John R Strickling

6 DATE OF BIRTH (month, day, and year) Aug 17 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46		12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Stockslager

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant John Strohecker
(Address) 525 N Milton Ave

15 Date AUG 16 1920 ROBERT E. KRAMER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/13 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1- 1920, to Aug 13 1920, that I last saw h[illegible] alive on Aug 5 1920, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) E. E. Glass, M. D.

8/13 1920 (Address) 1436 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 17 1920
20 UNDERTAKER	ADDRESS
Millard B Callender	1760 Bank

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1045747

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045747

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 Glenolden ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Wheatley

Father Melvin Wheatley

Mother Emma Wheatley

(Residence in Baltimore: No. 600 Glenolden ave St.; ...yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) —

6-DATE OF BIRTH, Aug. 15, 1920
(Month) (Day) (Year)

7-AGE, 4 hours

If LESS than 1 day, 4 hrs. or ... min.

...yrs. ...mos. ...ds.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Melvin Wheatley

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Emma Shanks

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Melvin W. Wheatley

(Address) 600 Glenolden Ave

15- AUG 16 1920 ROBERT B. KRAUTER

Filed ..... 191.. (DEPUTY) Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 15, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 15- 1920, to Aug. 15- 1920, that I saw h[illegible] alive on Aug. 15- 1920, and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Probable incomplete Coronary Occlusion of Coronary Artery, Heart

(R. Bruce Bailey)

Part 4 hours

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) —

(Duration) ...yrs. ...mos. ...ds.

(Signed) Carlton McCook M. D.

Aug. 15, 1920 (Address) 1207 W. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Baltimore County

DATE OF BURIAL, Aug. 16, 1920

20-UNDERTAKER Josiah Dyer

ADDRESS Woodsmouth

N.B.—Every item of information should be carefully supplied. ACCURACY in stating the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L045748

HEALTH DEPARTMENT—CITY OF BALTIMORE

L045748

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney Miller

(a) RESIDENCE. NO. 324 Pearl ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 10-1919

7 AGE — Years | 11 Months | 5 Days | If LESS than 1 day.....hrs. or .....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: George Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rose Siegel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Sarah Miller 324 Pearl St.

AUG 16 1920

ROBERT F. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug. 15 1920

17 I HEREBY CERTIFY, That I attended deceased from aug. 9 1920 to aug 15 1920 that I last saw him alive on aug 15 1920 and that death occurred, on the date stated above, at 8:00 a.m.

The CAUSE OF DEATH* was as follows:

Whooping cough

(duration) — yrs. — mos. 30 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) B Macgowan, M. D.

aug 15 1920 Address) Sydenham Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mehrer M Harmel

DATE OF BURIAL: 8/16 1920

20 UNDERTAKER: Jack Lapkis

ADDRESS: 1411 E Balto

N. B.—WHITE LABEL. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

4-14—M. & T.—2000 Blks.

Wobres

45-749

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 2045 749

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Mrs Aaron Wobres~~

(Residence in Baltimore: No. 1419 W Balto St ~~Life~~ 20 yrs. S... yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June 9 (Month) (Day), 1898 (Year)

7-AGE, 21 yrs. 7 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

9-BIRTHPLACE, (State or Country), New York.

PARENTS.

10-NAME OF FATHER, Abraham Wobres

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Bessie Pursner

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Balto St

15-

Filed ....., 191.... Registrar.

AUG 16 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 8 1920, to Aug 16 1920, that I saw him alive on Aug 16 1920, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Acute Tonsillar abscess, gangrenous cellulitis of neck. (Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Streptococcus Septicaemia acute myocarditis (Duration) ....yrs. ....mos. 3 ds.

(Signed) J. H. Steindler M. D.

Aug. 16, 1920 (Address) 1203 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 8 ds. In the State Life yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 1419 W. Balto St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herring Run

DATE OF BURIAL, 8-17, 1920

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto

N.B.—Every item of information should be carefully supplied. ACCURATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

2045750

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 2045750

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 702 - Luzerne St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jan Olipant,

(Residence in Baltimore: No. 702 - S. Luzerne St.; yrs. 11 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
M	W	Single

6-DATE OF BIRTH, 8 (Month) 25 (Day), 1914 (Year)

7-AGE,	If LESS than 1 day,
yrs. 11 mos. 14 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child,
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Edward Olipant

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Frona Michael

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frona Olipant. Mother.

(Address) 633 S. Luzerne Ave.

15-AUG 16 1920

Filed....., 191...

ROBERT P. BRAUER
DEPUTY REGISTRAR

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 15 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/14 1920, to 8/14 1920, that I saw h[illegible] alive on 8/14/20 191..., and that death occurred, on the date stated above, at 6.00 a m.

The CAUSE OF DEATH* was as follows:

Toxemia

(Duration)....yrs....mos. 2 ds.

CONTRIBUTORY (Secondary) Hem. Cabitis

(Duration)....yrs....mos. 21 ds.

(Signed) J. H. Garnell M. D.

(Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus.	Aug. 16, 1920

20-UNDERTAKER	ADDRESS
M. F. Sadowski.	705 S. Ann

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045751 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045751

104

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 318 S. Robinson ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert M. Diedrich

(a) RESIDENCE. NO. 318 N. Robinson ST., WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

E should be stated EXACTLY. ... should state
at it may be properly classified. Ex... statement of OCCUPA-
s on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): ~~May~~ July 13 20

7 AGE: Years | Months 1 | Days 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment In which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Albert Diedrich

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lillian Plumhoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Lillian Diedrich

(Address) 318 N. Robinson

15 Filed AUG 16 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1920

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1920, to Aug. 14. 1920.

that I last saw h... alive on Aug. 13. 1920.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cystitis cervicis

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) ~~Cystitis~~ Tb

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. C. Hagen, M. D.

19 20 (Address) 1600 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Aug 16 1920

20 UNDERTAKER: Philip Herring — ADDRESS 2016 Eutaw

Spec.—8-24-14—M. & T.—2000 Bks.

D.45752

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45752

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 19 N. Duncan ST.; 6 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie R Miller

(Residence in Baltimore: No. 19 N. Duncan St.; Life yrs., mos., ds.)

N. B.—Every item of information must be carefully supplied. Exact statement of OCCUPATION is very important. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH Jan 24 (Month) (Day), 1884 (Year)

7-AGE.	If LESS than 1 day,
35 yrs. 7 mos. 12 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Joseph Mathews

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Miller

(Address) 19 N. Duncan

15-

AUG 16 1920

Filed....., 191...

Robert P. Harrison,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 13, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 7-24 1920, to 8-13 1920, that I saw h[illegible] alive on 8-12 1920, and that death occurred, on the date stated above, at 4.30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs

..... (Duration) ..... yrs. ..... mos. 1 ..... ds.

(Signed) W. J. and Russell M. D.

....., 191... (Address) 800 N. Bait Mk

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Aug 17, 1920

20-UNDERTAKER	ADDRESS
Chas C Miller	233 N Jeffers St

Spec.—8-24-14—M. & T.—2000 Bks.

D.45753

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45753

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 Ashland Ave ST.; 1 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie A. Harps

(Residence in Baltimore: No. 1731 Ashland Ave St.; 77 yrs. 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan 28th, 1843 (Month) (Day) (Year)

7-AGE, 77 yrs. 6 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, John M. Kuhn

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Mary E. Hild

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank H. Harps

(Address) 1721 Ashland Ave

15-

AUG 16 1920

Robert P. Harrison,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 15th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 29th 1920, to Aug 14th 1920, that I saw h alive on Aug 14th 1920, and that death occurred, on the date stated above, at 6 15 m.

The CAUSE OF DEATH* was as follows:

Chronic Disease of Heart

(Duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. mos. ds.

(Signed) E. Lemmon Rathbun M. D.

Aug 16th, 1920. (Address) 2432 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, New Cathedral — DATE OF BURIAL, Aug 18th, 1920

20-UNDERTAKER Geo. M. Fink & Son — ADDRESS 811 W. Lafayette

Funeral Directors & Embalmers.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45754

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45754

64

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2405 E Federal St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma E Quinn Gates

(Residence in Baltimore: No. 2405 E Federal St St.; 17 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W

5-~~SINGLE, MARRIED,~~ WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, Sept (Month) 9 (Day), 1840 (Year)

7-AGE, 79 yrs. 11 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John McCubbin

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Margaret Mumma

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Lena Bull

(Address) 2405 E Federal

15-

Filed AUG 16 1920, 191.....

Robert P. Harrison, Registrar.

~~Burial Permit Issued~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 15 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from aug 14 1920, to aug 15 1920, that I saw h~~e~~r alive on aug 14 1920, and that death occurred, on the date stated above, at 1220 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration).....yrs.....mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 8 yrs. .....mos.....ds.

(Signed) R G Davis M. D.

....., 191... (Address) 1509 N Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Parkwood Cem. DATE OF BURIAL, Aug 17, 1920

20-UNDERTAKER E L Roy Shipley ADDRESS 125 E Math

N. B.—Every item of information should be carefully supplied. Age should be stated EXACTLY. OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement

Spec. 6-9-19—H. P. Co.—1000 Blks.

D45755 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45755

CERTIFICATE OF DEATH. 4/2

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Hamilton Ave. near Hillen Road ST.: (WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Belle Crowder

(a) RESIDENCE. No. Hamilton Ave. near Hillen Road ST.: WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write one word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Crowder

6 DATE OF BIRTH (month, day, and year) Nov 6th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 237

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chestnut Hill Maryland

PARENTS

10 NAME OF FATHER Charles Burkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rock Bottom Pennsylvania

12 MAIDEN NAME OF MOTHER Olivia C. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chestnut Hill Maryland

14 Informant Frederick Crowder

(Address) Hamilton Md

15 Filed AUG 16 1920 Robert P. Harrison, Registrar

Burial Permit (Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 13 . 17 . to Aug 14 . 1920 that I last saw h alive on Aug 14 1920 and that death occurred, on the date stated above, at 12 a.m.

The CAUSE OF DEATH* was as follows:

Exhaustion of Toxaemia

(duration) yrs. ds.

CONTRIBUTORY (Secondary) Carcinoma of Rectum with apparent metastases (duration) mos. ds.

18 Where was disease contracted if not at place of death? into the Pelvic viscera

Did an operation precede death? yes Date of 2 years ago

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Claud Simms, M. D.

(Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hiss Cemetery	Aug 17 1920

20 UNDERTAKER Fredk Lassahn & Sons

ADDRESS Fulleton Md

mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

Spec.—8-24-14—M. & T.—2000 Bks.

D.45756

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45756

CERTIFICATE OF DEATH.

REGISTERED NO. C 792

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 W 28 St, ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza L. Cowley

(Residence in Baltimore: No. 410 W 28 St / St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov (Month) 3 (Day), 1848 (Year)

7-AGE, 71 yrs. 9 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Balto. Co.

PARENTS.

10-NAME OF FATHER, Rob. McClelland

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Mrs Baxter

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam'l Cowley

(Address) 410 W. 28 St

15- AUG 16 1920, 191.... Robert P. Harrison, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 11, 1920, to Aug 16, 1920, that I saw h.. alive on Aug 15, 1920, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. D. Pearl M. D.

Aug 16, 1920 (Address) 2105 N. Calvert

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Aug 18, 1920

20-UNDERTAKER H. S. Marshall — ADDRESS 339 Fall Rd.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in YEARS, MONTHS and DAYS. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1945757

HEALTH DEPARTMENT—CITY OF BALTIMORE

1945757

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1028 Cathedral St.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pliny Earl Wigart

(a) RESIDENCE. NO. 1028 Cathedral ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara J. Adams

6 DATE OF BIRTH (month, day, and year) Nov. 16, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	58	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retail Shoe Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) OHS

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Bascom Wigart

11 BIRTHPLACE OF FATHER (city or town) Baltimore,
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Wallace

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Maryland

14 Informant Clara J. Wigart
(Address) 1028 Cathedral Street

AUG 17 1920 ROBERT I. KRAMER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1920, to Aug 13, 1920,
that I last saw him alive on Aug 13, 1920,
and that death occurred, on the date stated above, at 4 P M.
The CAUSE OF DEATH* was as follows:

Uraemia (Coma) 2 hrs

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. L. Gibney M.D., M. D.

Aug 1, 1920 (Address) 677 W. Mount Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	8/17, 1920
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular to state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) nffection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart fnilure," "Hemorrhage,""Inanition,""Marasmus,""Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nnture of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Interstitial Nephritis
mtk

Spec.—8-24-14—M. & T.—2000 Bks.

0645758 HEALTH DEPARTMENT—CITY OF BALTIMORE 0645758

151

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH Baltimore

CITY OF BALTIMORE: (No. 434 N. Fremont ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Sanders

(Residence in Baltimore: No. 434 N. Fremont St.; yrs. 3 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, May (Month) 14 (Day), 1920 (Year)

7-AGE, 3 yrs. 2 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Robert Sanders

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Henrietta Downey

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosetta Keston

(Address) 434 N. Fremont St

15- AUG 17 1920 ROBERT P. FOUTER

Filed....., 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH August (Month) 16. (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 2 1920, to August 16 1920, that I saw him alive on August 15 1920, and that death occurred, on the date stated above, at 6:15 A m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Premature Birth

(Duration) 2 months infant yrs. mos. ds.

(Signed) W. H. Hayman M. D.

8-16, 1920 (Address) 243 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 3 mos. 2 ds. In the State yrs. 3 mos. 2 ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 434 N. Fremont St.

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Aug 17, 1920

20-UNDERTAKER Wm. H. Chase & Son — ADDRESS 1400 Mosher

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

L045759 HEALTH DEPARTMENT--CITY OF BALTIMORE L045759

CERTIFICATE OF DEATH

79-010

REGISTERED No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Carlford Manor ST.: 27 (WARD)

2-FULL NAME Anna A. H. Ford

(Residence in Baltimore: No. Carlford Manor, Park Heights Ave St.: 51 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Oct 9 (Month), (Day), 1857 (Year)

7-AGE: 62 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Saint Louis

PARENTS

10-NAME OF FATHER: Addison Hardcastle

11-BIRTHPLACE OF FATHER (State or country): Easton, Md

12-MAIDEN NAME OF MOTHER: Octavia Oberandn

13-BIRTHPLACE OF MOTHER (State or country): St Louis

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles E Ford

(Address) Carlford Manor, Parkheights Ave

15. AUG 17 1920 Filed ....., 191.... ROBERT P. BEAUTER REGISTRAR

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: August 15th (Month) (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7th, 1920, to August 15th 1920, that I saw h ex alive on Aug 15th, 1920, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 3 yrs. mos. ds

Contributory (SECONDARY) Senile colloid Abdominal type

(Duration) yrs. mos. 11 ds.

(Signed), Thomas L Shearer M. D.

Aug 16, 1920 (Address) 905 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: aug 17, 1920

20-UNDERTAKER: R&H J Turner & Son

ADDRESS: 1424 E Broadway

1945760 HEALTH DEPARTMENT—CITY OF BALTIMORE 1945760

CERTIFICATE OF DEATH.

156

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital ST.: 11 WARD)
REGISTERED NO. C.....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry. Gothoack
(Residence in Baltimore: No. 227 E Biddle St. St.; (yrs. 50) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M | 4-COLOR OR RACE, W | 5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED~~, (*Write* the word.) Married

6-DATE OF BIRTH, Not known (Month) (Day), 1851 (Year)

7-AGE, 69 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.
10-NAME OF FATHER, Michael Gothoach
11-BIRTHPLACE OF FATHER (State or Country), Russia
12-MAIDEN NAME OF MOTHER, Hetta Pollus
13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Abe Krovatz
(Address) 227 E Biddle St

15- AUG 17 1920
Filed....., 191... ROBERT F. BRAUTER Registrar.
Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 16 (Day), 1920 (Year) 9 30 P.M.

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to ...death on the day stated above.

The CAUSE OF DEATH* was as follows:
Ill. Gas Asphyxia
(Duration)..... yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Cardiac Asthenia
(Duration) yrs. mos. 1 ds.
(Signed) Jno. C. Blades M. D.
(Coroner)
8/16/20, 191... (Address) 143 N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death..... yrs..... mos..... ds. In the State 50 yrs..... mos..... ds.
Where was disease contracted, if not at place of death? 227 E Biddle St
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship | DATE OF BURIAL, 8 17, 1920
20-UNDERTAKER Jack Levin | ADDRESS 1411 E Balt

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

1045761

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045761

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child Hospital St. 18 WARD) 104

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Jones

(Residence in Baltimore: No. Nursery & Childs Hospital St.; ....yrs. 7 mos. 19 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, Dec 26, 1919. (Month) (Day) (Year)

7-AGE, ...yrs. 7 mos. 19 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... Jd.

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. George Day

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Irma Jones

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred Sabyn

(Address) N. Childs Hospital

15- AUG 17 1920 ROBERT F. [illegible]

Filed....., 191..... Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 16., 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Aug 16 1920, that I saw him alive on Aug 16 1920 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

C. Malnutrition

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Ileo Colitis

(Duration) ....yrs. ....mos. 8 ds.

(Signed) J. J. Finnegan M. D.

Aug 17, 1920 (Address) 2007 E. Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 7 yrs. 7 mos. ds. In the State X yrs. 7 mos. 19 ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Aug 17, 1920.
20-UNDERTAKER George J. Smith	ADDRESS 2028 W. Fayette St

D45762 HEALTH DEPARTMENT—CITY OF BALTIMORE D45762

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1554 Woodyear St. 15 WARD) REGISTERED No. C. 91

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacqueline Winston

(Residence in Baltimore: No. 1554 Woodyear St. St.: yrs., 11 mos. 7 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, September 9, 1919 (Month) (Day) (Year)

7-AGE, ...yrs. 11 mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none (infant)
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Virginia

PARENTS.

10-NAME OF FATHER, Ashby Winston

11-BIRTHPLACE OF FATHER (State or Country) Virginia

12-MAIDEN NAME OF MOTHER Imogene Hamilton

13-BIRTHPLACE OF MOTHER (State or Country) Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. Winston

(Address) 1554 Woodyear St.

15- ROBERT F. IRAUTH

Filed AUG 17 1920 1919 ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 16, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

August 16, 1920 (Address) 28 S. Exeter St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL Bonbere Wd. Kings Bonds DATE OF BURIAL Aug. 20

20-UNDERTAKER Daniel Hennessy ADDRESS 28 E. Exeter St

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045763

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045763

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital 23 WARD)

2-FULL NAME Bertha Funcke

(a) RESIDENCE. NO. 1710 Hanover St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 7th, 1875

7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dressmaker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Karl Funcke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Kunish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Bay View Hospital Records.
(Address)

AUG 17 1920 ROBERT E. SLAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14th, 1920

17

I HEREBY CERTIFY, That I attended deceased from August 9th., 1920, to August 14th 1920, that I last saw her alive on August 14th, 1920, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis?

(Signed) L. J. Rigney. M. D.

. 19 (Address) Bay View Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park.	Aug 17 1920
20 UNDERTAKER	ADDRESS
Margaret E. Flynn	1711 Light St

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45764

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

D45764

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1903 Patterson Place ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice L. Dawson

(a) RESIDENCE. NO. 1903 Patterson Place WARD.....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 10/1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry V Dawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mahala Danson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Adelard Dawson
(Address) 1903 Patterson Place

15 Filed AUG 17 1920 19.... ROBERT B. HEALY Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 13, 1920, to Aug 16, 1920, that I last saw her alive on Aug 16, 1920, and that death occurred, on the date stated above, at 7 50 a.m.

The CAUSE OF DEATH* was as follows:

Summer Diarrhoea

(duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Geo. Seymour, M. D.

19 (Address) 2529 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Harford Rd	Aug 18 1920
20 UNDERTAKER	ADDRESS
Wm Cook Sons	North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Numer.

945765

HEALTH DEPARTMENT—CITY OF BALTIMORE

945765

CERTIFICATE OF DEATH.

104

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 Gorsuch ave St.; 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma M Numer

(Residence in Baltimore: No. 1411 Gorsuch ave St.; ...yrs., 4 mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) W

6-DATE OF BIRTH, April 17, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. 30 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), 1411 Gorsuch ave Baltimore md

PARENTS.

10-NAME OF FATHER, Fielo Numer

11-BIRTHPLACE OF FATHER (State or Country), Baltimore md

12-MAIDEN NAME OF MOTHER Eleanor Herman

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M Numer

(Address) 1411 Gorsuch ave

15- AUG 17 1920 ROBERT B KRAUTER Registrar

Filed....., 191.... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 16, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 13 1920, to August 16 1920, that I saw her alive on August 16 1920, and that death occurred, on the date stated above, at 1230 a m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ...yrs. ...mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ...yrs. ...mos. 3 ds.

(Signed) Haywood Wallbrook M. D.

August 16 1920 (Address) 16 E Gorsuch ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Aug 17, 1920

20-UNDERTAKER George J. Ruth ADDRESS 773 Hanford ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045766

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045766

104

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 S. East Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Heid

(a) RESIDENCE. NO. 28 S. East Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16-19

7 AGE — Years: 1 — Months: 3 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Gustav Heid

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Jennie Bertein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Gustav Heid (Address) 28 S East Ave

15 FILED: AUG 17 1920 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 14. 1920 to Aug 16 1920

that I last saw him alive on Aug 14 1920

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Maxwell L Myers M.D.

(Address) 314 E Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Aug 17 1920

20 UNDERTAKER: Philip Henry — ADDRESS: 5016 Belair

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Each item should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

045767 | 129 | 045767

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Franklin Square Hospital St.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Ella Gossom

(a) RESIDENCE. No. 841 W. 37th St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

Single

6 DATE OF BIRTH (month, day, and year) October

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
43				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Pr William Co Va
(State or country)

PARENTS

10 NAME OF FATHER Thos E Gossom.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Marion Garner

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant M E Gossom
(Address) 1623 N North Ave.

15 Filed AUG 17 1920, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1920, to Aug 16, 1920, that I last saw h-m alive on Aug 11, 1920, and that death occurred, on the date stated above, at 11.10 a. m.

The CAUSE OF DEATH* was as follows:

acute Nephritis (acidosis)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) operation for fibroid Hysterectomy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Aug 2, 1920

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lyman S. Tebault, M. D.

, 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Baltimore Co Md

DATE OF BURIAL Aug 19. 1920

20 UNDERTAKER M Fahey & Sons

ADDRESS 1627 W North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be stated EXACTLY. PHYSICIANS should be careful in the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45768 HEALTH DEPARTMENT—CITY OF BALTIMORE D45768

CERTIFICATE OF DEATH. 104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 S. Chapel ST.: 7 WARD)

2-FULL NAME Franklin Branigan

(a) RESIDENCE. NO. 205 S. Chapel ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. 1

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 13 - 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Walter E. Branigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jennie Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Walter E. Branigan
(Address) 205 S. Chapel St

15 AUG 17 1920 ROBERT F. CRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1920, to Aug 16, 1920, that I last saw him alive on Aug 15, 1920, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Ted Heise M. D.

(Address) 1937 Gre[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Aug 17 1920

20 UNDERTAKER F. A. Krause & Son ADDRESS 713 Hanover St

Spec.—8-24-14—M. & T.—2000 Bks.

D45769 HEALTH DEPARTMENT—CITY OF BALTIMORE D45769

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1324 Homewood Ave.; 9 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James McGraw

(Residence in Baltimore: No. 1324 Homewood Ave St.; 30 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Sept. 14th, 1888
(Month) (Day) (Year)

7-AGE, 32 yrs. 11 mos. 1 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Finisher on Straw Hats
(b) General nature of industry, business, or establishment in which employed (or employer)... Redwood Packing Co

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Nicholas P. McGraw

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Margaret Furlong

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Margaret McGraw mother

(Address) 1324 Homewood Ave

15- AUG 17 1920 ROBERT E. LEAUTER
Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 15 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8/13 1920, to 8/15 1920, that I saw h[er] alive on 8/15 1920, and that death occurred, on the date stated above, at 6:40 a. m.

The CAUSE OF DEATH* was as follows:

1 Septicemia

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) abscess of cheek

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) A. T. Bernardburgh M. D.

8/16, 1920 (Address) 914 E. Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cem.

DATE OF BURIAL, Aug. 17, 1920

20-UNDERTAKER Edward W. Conklin

ADDRESS 927 E. Eager St.

N. B.—WRITE PLAINLY, with pen and ink. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1045770 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045770

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 720 S Keyser ST.: W WARD) REGISTERED No. C

2-FULL NAME Adam Bajorski

(Residence in Baltimore: No. 720 S Keyser St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED.~~ (*Write* the word.) Single

6-DATE OF BIRTH, Aug (Month) 15 (Day) 1920 (Year)

7-AGE, ... yrs. ..... mos. 1 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Frank Bajorski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Ernestine Prokocki

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Bajorski

(Address) 720 S Keyser St

15- AUG 17 1920 ROBERT P. BEAUTER Registrar of Vital Statistics

Filed ....., 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 15 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Albert Gill Mackey (Coroner.) M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus.	Aug 17, 1920.
20-UNDERTAKER	ADDRESS
M. F. Sadowski	905 S. Ann

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

2045771

HEALTH DEPARTMENT—CITY OF BALTIMORE

2045771

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathaniel Boykin

(a) RESIDENCE. No. 127 Chapel St, ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER William Boykin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed AUG 17 1920, 19 ROBERT E. CLAUDER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 13, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1920 to August 13, 1920

that I last saw h in alive on August 13, 1920

and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Abdominal wall

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia & Cachexia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? not as yet

What test confirmed diagnosis? Micro-Section

(Signed) F. A Holden, M. D.

8/14/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	Aug 17th 1920
20 UNDERTAKER	ADDRESS
Harry A. Vodery	1725 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1045-772 — 1045-772

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 Bruce ST.; 15 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizebeth Crawford

(Residence in Baltimore: No. 1427 Bruce St.; abt 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	Colored	Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1 (Year)

7-AGE, 49 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), St. Mary Co. Maryland

PARENTS.

10-NAME OF FATHER, Alfred Gladdeh

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis Crawford

(Address) 1427 Bruce St.

15- AUG 17 1920 ROBERT B. KRAUTER

Filed ....., 191.. .....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 13 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1920, to Aug 13 1920, that I saw her alive on Aug 13 1920 191, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Duration) — yrs. — 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Anasarca

(Duration) + yrs. + mos. 10 ds.

(Signed) Charles E. Clark M. D.

Aug 14, 1920 (Address) 1306 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Aug 17, 1920

20-UNDERTAKER JAMES H. DENNIS — ADDRESS 1303 PRESTMAN ST.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D45773 HEALTH DEPARTMENT—CITY OF BALTIMORE. D45773.

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 741 Prince st ST.: 17 WARD)

REGISTERED No. C....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Verney Moore-

(Residence in Baltimore: No. 741 Prince st- St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, March (Month) 26 (Day), 1909 (Year)

7-AGE, 11 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School girl
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore city-

PARENTS.

10-NAME OF FATHER, Robt F. Moore

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Aurlia Bosuell

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Aurlia Dobson

(Address) 741 Prince st

15-

AUG 17 1920

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 15 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) yrs. mos. ds.

(Signed) H K Goodrich (Coroner.) M. D.

8-16 1920 (Address) 117 W Saratoga st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Aug 17, 19....

20-UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D45774 HEALTH DEPARTMENT---CITY OF BALTIMORE D45774

CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO. C 64

CITY OF BALTIMORE: (No. 4503 Fernhill Av St. 27 WARD)

2-FULL NAME Edwin J Mabbatt

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 4503 Fernhill Av St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: July 14 (Month) (Day), 1867 (Year)

7-AGE: 53 yrs. 1 mos. ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Jewel business
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Joseph Mabbatt

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Anne Whitaker

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Agnes Mabbatt

(Address) 4503 Fernhill Av

15-

Filed AUG 17 1920 ROBERT B KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: August (Month) 15 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1920, to, Aug. 15 1920, that I saw h[illegible] alive on Aug. 15 1920, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia

(Duration) yrs. mos. 4 ds.

Contributory (SECONDARY): Pulmonary Edema

(Duration) yrs. mos. 2 ds.

(Signed), M. S. Schumm M. D.

Aug. 15 1920. [Address] M. S. Schumm

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: 8/17 1920

20-UNDERTAKER: Jones & Jones — ADDRESS: 14 N Green St

Spec.—6-9-19—H. P. Co.—1000 Bks.

10-098

10-45775 HEALTH DEPARTMENT—CITY OF BALTIMORE 10-45775

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (NO. 659 E Clement ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George L LaBarre.

(a) RESIDENCE. NO. 659 E. Clement ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Geo. LaBarre Jr.
(Address) 659 E. Clement St.

15 Filed AUG 17 1920 ROBERT F. [illegible] Registrar

Social Service Dept

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1920, to Aug 16, 1920
that I last saw h[illegible] alive on Aug 15, 1920,
and that death occurred, on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:
Acute Cardiac dila-
tation

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertension Sclerosis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ,

Was there an autopsy? No

What test confirmed diagnosis? Refused

(Signed) J. H. Hawkins, M. D.

8/16 1920 (Address) 1 E Randall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Aug. 18, 1920
20 UNDERTAKER	ADDRESS
E. O. Fanning	1460 Battery Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1045776

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

174 1045776

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 615 n Bond St. Ward 7)

REGISTERED No. C

(If death occurred in a hospitnl or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Whitfield

(Residence in Baltimore: No. 615 n Bond St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	Col.	Single

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 39 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Labr
(b) Gencral nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), N C

PARENTS.

10-NAME OF FATHER, Arnold Whitefield

11-BIRTHPLACE OF FATHER (State or Country). N C

12-MAIDEN NAME OF MOTHER Frances Beller

13-BIRTHPLACE OF MOTHER (State or Country). N C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Young

(Address) 629 W Eden St

15- AUG 17 1920 191... ROBERT B KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 11 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pneumonia hit by Coal bucket on B & O Prem, (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Laureal Cemetery	Aug 18 19....
20-UNDERTAKER	ADDRESS
R B Frost	1406 McElderry

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045777

1045777

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 21 WARD)

2-FULL NAME Hattie Fletcher

(a) RESIDENCE. No. 869 Ostend St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigarmaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Edward Alibi

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mary Carrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records, (Address) New City Hospital.

15 AUG 17 1920 ROBERT J. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 13, 1920

17 I HEREBY CERTIFY, That I attended deceased from August 4, 1920 to August 13, 1920 that I last saw h...er alive on August 13, 1920 and that death occurred, on the date stated above, at 10:30 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Metastases to regional glands (duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic especial test

(Signed) W. H. Sherman, M. D.

8/14/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Aug 17 1920
20 UNDERTAKER	ADDRESS 1140 N.
Brown & Freland.	Schroeder St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D. 45778 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 45778

1047

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 754 W Fayette St. St.; 4 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dewey F. Miller

(Residence in Baltimore: No. 754 W. Fayette St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	

6-DATE OF BIRTH, Feb 20, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 7 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), B City

PARENTS.

10-NAME OF FATHER, F. Miller

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eva Maddix

13-BIRTHPLACE OF MOTHER (State or Country), Balt City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Miller

(Address) 754 Fayette St

15- Robert P. Harrison,

Filed AUG 17 1920, 191 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 16, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Food Poisoning

(Duration) ....yrs. ....mos. 4 ds.

(Signed) M K Gorman C.H. M. D. (Coroner.)

8-16, 1920 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Arlington Hill Cem. DATE OF BURIAL, 8/17, 1920

20-UNDERTAKER M. J. Brown ADDRESS 1420 E. Pratt

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D.45779

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45779

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern Hospital ST.; 12 WARD) REGISTERED No. C 15

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Fowler.

(Residence in Baltimore: No. ..... St.; ..... yrs., ... mos. ..... da.)

THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK—THE ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, August (Month), 14 (Day), 1920 (Year)

7-AGE, ... yrs. ..... mos. ..... da.	If LESS than 1 day, 5 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Baby
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Southern Hospital. Baltimore. Md.

PARENTS.

10-NAME OF FATHER, Edward W. Fowler

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Gertrude M. Evans.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed AUG 17 1920, 191.....

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month), 14 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 14 1920, to Aug 14 1920, that I saw her alive on Aug 14 1920, and that death occurred, on the date stated above, at 7.9 m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

..... (Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... da.

(Signed) W. Arthur Davis M. D.

Aug. 14., 1920. (Address) 1611 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, AUG 1 1920, 191...
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

Baltimore City Health Department

D. 45780 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 45780

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2421 Hudson St. 12 WARD) REGISTERED No. C 1822

2-FULL NAME Lonie McKnight

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2421 Hudson st St.; 1 yrs, mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)
F.	C.	Single

6-DATE OF BIRTH, [illegible] 1 (Month) (Day) (Year)

7-AGE, 19 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- Filed AUG 17 1920, 191 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 15 24 (Month) (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to X death on the day stated above.

The CAUSE OF DEATH* was as follows: Endocarditis Interstitial

Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

1920 (Address) 1632 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY DATE OF BURIAL, 19

20-UNDERTAKER [illegible] ADDRESS [illegible] AUG 17

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state

D45781 HEALTH DEPARTMENT—CITY OF BALTIMORE D45781

CERTIFICATE OF DEATH.

1200

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 520 E. 26th St., 9 Ward)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Hogen

(Residence in Baltimore: No. 520 E. 26th St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	S.

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 50 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 887

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

Robert P. Harrison, Registrar.

AUG 17 1920 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 5, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH was as follows:

Chronic Interstitial Nephritis

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

Aug 6 1920 (Coroner.) M. D.

....., 19.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
PUBLIC CEMETERY	AUG 16 1920
20-UNDERTAKER	ADDRESS
Commissioners Board.	

Jno. Wm. E. WOODALL

Very item of information should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Every question should be answered. Information important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45782

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45782

CERTIFICATE OF DEATH.

REGISTERED NO. 82

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Simonds

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records, (Address) New City Hospital.

15 Filed AUG 17 1920 Robert P. Harrison, Registrar

Burial Permit Clerk]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 13, 1920

17 I HEREBY CERTIFY, That I attended deceased from August 10, 1920 to August 13, 1920 that I last saw her alive on August 13, 1920 and that death occurred, on the date stated above, at 4:50 P.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis (? cerebral thrombosis)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary thrombo sis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? No especial test

(Signed) B Herman, M. D.

8/13, 1920 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL DEC 9 1920 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health

Per. Wm. R. WOODALL

...mation should be care... CAUSE OF DEATH in p... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

10.45783

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.45783

CERTIFICATE OF DEATH.

104 V

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Fenyes

(a) RESIDENCE. NO. 917 S Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 30 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Louis Fenyes

11 BIRTHPLACE OF FATHER (city or town) Hungary
(State or country)

12 MAIDEN NAME OF MOTHER Germaine Bleche

13 BIRTHPLACE OF MOTHER (city or town) France
(State or country)

14 Informant Hospital Record
(Address) Johns Hopkins

15 Filed 19 Robert P. Harrison, Registrar

AUG 17 1921 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1921

17

I HEREBY CERTIFY, That I attended deceased from Aug 12, 1921, to Aug 17, 1921, that I last saw him alive on Aug 17, 1921, and that death occurred, on the data stated above, at 8:40 a.m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Patients home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 18 1921

20 UNDERTAKER John Grebliauskas ADDRESS 425 S. Paca St.

certificates.

TE PLAINL
nation should be
CAUSE OF DEATH
TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

245784 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 45784

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Little Sisters of the Poor REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Lannan

(Residence in Baltimore: No. Little Sisters of the Poor St.) (.....yrs. .....mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, July (Month) ..... (Day) ....., 1852 (Year)

7-AGE, 68 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Lannan

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Ellen Griffen

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed ....., 191.....

~~Burial Permit Clerk.~~ Registrar.

AUG 17 1920 Robert P. Harrison,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 16th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November, 191..., to Aug 16 191...,

that I saw h[illegible] alive on Aug 16 191...,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

.....

Cerebral apoplexy

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Apoplectic convulsions

..... (Duration) .....yrs. .....mos. 1 Day ds.

(Signed) F. C. Wimer M. D.

Aug 17, 191... (Address) 113 S Paca St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 8 yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Aug 18, 1920

20-UNDERTAKER F. C. Wiedefeld & Co ADDRESS Fremont Av

CAUSE important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Blks.

10.45785 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.45785

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. St.: 8 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Chas. Rupprecht

(a) RESIDENCE. No. 2237 E. Hoffman St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Charles Rupprecht

6 DATE OF BIRTH (month, day, and year) Nov. 30, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brewer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ernest Rupprecht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Furstenau

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ernest Rupprecht (Address) 601 Morgan St. Gilbert Sta.

15 Filed AUG 17 1920 Robt. P. Harrison, Registrar (Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1920

17 I HEREBY CERTIFY, That I attended deceased from June 23 1920 to Aug 16, 1920, that I last saw h— alive on Aug 16 1920, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis, Cir-
-rhosis of Liver

(duration) 1 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6/24

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Louis A. Rodgers M. D.

(Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Aug 17 1920
20 UNDERTAKER	ADDRESS
J Herwig & Co	1008 Aliceanna

CAUTION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.45786 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.45786

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp (ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Hamman

(a) RESIDENCE. No. 1122 Caroline St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 4/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23 1919

7 AGE Years 11 Months 24 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Hamman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Augusta Rahmis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Husband 1122 E. Caroline

15 Filed AUG 17 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1920, to Aug 16, 1920, that I last saw he alive on Aug 16, 1920, and that death occurred, on the date stated above, at 2.35 P m.

The CAUSE OF DEATH* was as follows:

Dysentery Bacillary (Flexner)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Pts home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stool Culture

(Signed) W. M. Kelly, M. D.

, 19 (Address) Visit

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

DATE OF BURIAL: Aug 17 1920

20 UNDERTAKER: John Herwig & Co

ADDRESS: 2008 Aliceanna

CAUTION is very important. See instructions on reverse side.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.45787 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.45787

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 820 N. Port St. St.; 17 Ward)

2-FULL NAME Katherine Caspare

(a) RESIDENCE. No. 820 N. Port St. St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of wife of late Frank C. Caspare

6 DATE OF BIRTH (month, day, and year) Oct 9th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	10	6	

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Rausch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Caspare (Address) 820 N. Port St.

15 Filed G 17 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15th, 1920

17 I HEREBY CERTIFY, That I attended deceased from May 30th, 1920, to Aug 15th, 1920, that I last saw h.... alive on Aug 10th, 1920, and that death occurred, on the date stated above, at 12.45 m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(duration) yrs. 2 mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robt J. Munroe, M. D.

, 19 (Address) 510 N. Mount ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 18 20
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1531 W. Lombard

1045788 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045788

160

CERTIFICATE OF DEATH.

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1522 E. Eager St.; 7 WARD)

2-FULL NAME Clara J. Knellinger

(Residence in Baltimore: No. 1522 - E - Eager St.; 5 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Sept (Month) 11 (Day), 1880 (Year)

7-AGE. 39 yrs. 11 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At Home
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, Jos. Unger

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Knellinger

(Address) 1522 E. Eager

15- Filed AUG 18 1920 191.... ROBERT B. HEALY Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 15 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Injury (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Injury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Suicide. cut throat with razor

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. H. Bradley M. D.
(Coroner)

8-19-1920 (Address) 14 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, Aug 18 1920

20-UNDERTAKER William Cole

ADDRESS 502 E North Ave

CAUSE OF DEATH to be filled in plainly and completely. Use no abbreviations or initials. Name the Disease causing Death, or, in deaths from violent causes, state the Means of Injury; and whether Accidental, Suicidal or Homicidal. Where practicable, a Medical Certificate should be obtained. Burial Permit will not be issued until this certificate is filed. Violation of any of the Regulations of the Board of Health is punishable by a fine of not more than $100.00. Physicians are required to report to the Health Department all cases coming under their observation. Midwives are required to report all births attended by them. Undertakers are required to report all deaths coming into their charge. Midwives and Undertakers are required to call at the Health Department for instructions. Midwives are required to report all births attended by them. Undertakers are required to report all deaths coming into their charge. Midwives and Undertakers are required to call at the Health Department for instructions. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1045789 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045789

CERTIFICATE OF DEATH. 37

1-PLACE OF DEATH Bay View Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeannette Harding

(a) RESIDENCE. NO. 1846 Eutaw ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER: Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant (Address): Bay View Hosp. Balto, Md.

15 AUG 18 1920 [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 15, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1920, to Aug. 15, 1920

that I last saw h[illegible] alive on Aug 15, 1920

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Fever

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Lung Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological test

(Signed) N. Fredericks, M. D.

8/16/1920 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Aug 18 1920
20 UNDERTAKER	ADDRESS
L. L. Brownford Son	1617 W. Monty

TION is very important. See instructions on

D45790

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D45790

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1700 n Dallas St. 8 WARD) REGISTERED No. C

2-FULL NAME William H Johnson

(Residence in Baltimore: No. 1700 n Dallas St.; yrs., mos. ds.)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Mar

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 50 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Junk Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE, (State or Country): Balto

PARENTS.

10-NAME OF FATHER, Benjamin Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary Foreman

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Johnson

(Address) 1700 n Dallas

15- AUG 18 1920 ROBERT I. GRIFFITH

Filed....., 191... Deputy Registrar.

CAUSE OF DEATH: In plain terms. Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 17, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) J. Wm. Bayley M. D. (Coroner.)

8-72 Lex (Address) Coroner

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Aug 19, 1920

20-UNDERTAKER Mrs R A Pratt ADDRESS 1725 Pulaski

1045-791 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045-791

CERTIFICATE OF DEATH.

105

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2708 Reese St. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mildred E. Brown

(Residence in Baltimore: No. 2708 Reese st, St. (yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) S

6-DATE OF BIRTH April 21, 1914 (Month) (Day) (Year)

7-AGE, 6 yrs. mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Milton Brown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rebecca Edwards

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rebecca Brown

(Address) 2708 Reese St

15- AUG 18 1920 Filed, 191 ROBERT B. [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 16, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry.) find that said deceased came to death on the date stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, McCulloh county — DATE OF BURIAL, Aug 18, 1920

20-UNDERTAKER Mrs Robt Elliott — ADDRESS 1725 Division St

CAUSE OF DEATH: Write plainly and fully. Use no abbreviations. Do not state mode of dying, such as heart failure, asthenia, etc., but the disease causing it. Also state contributory (secondary) causes, if any. If deaths from violence, state (1) means of injury, and (2) whether accidental, suicidal, or homicidal. If from accident, state where it occurred. If a woman, state whether pregnant, or whether death occurred within six weeks after labor. These facts are important. See instructions on back of certificate.

45792

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

169 45792

REGISTERED No. C

1-PLACE OF DEATH Naval Curtis Bay — 4

CITY OF BALTIMORE (No. ..... ST. ..... WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Ross.

(Residence in Baltimore: No. 793 N. Saratoga St.; (yrs., 2 mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M.	C	Single

6-DATE OF BIRTH, Not known. ..... (Month) ..... (Day), 1 ..... (Year)

7-AGE, 24 yrs. — mos. — da. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Fred Ross.

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Polly Paine

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Denis Easton

(Address) 916 E. ....

15- AUG 18 1920 ROBERT B. BEAUTER

Filed ....., 191.. ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 — 12 — , 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.

..... (Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... da.

(Signed) C. E. Hall, M. D. (Coroner)

9/16/20 (Address) 173 N. Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	aug 18 1920
20-UNDERTAKER Denis Easton	ADDRESS 916 Denna ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

045793

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 045793.

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 1204 E Eager ST.: 10 WARD)

2-FULL NAME Elizabeth M. Shock

(a) RESIDENCE. NO. 1204 E Eager ST., 10 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 10 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Harry K. Shock

6 DATE OF BIRTH (month, day, and year) Sept. 21 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frank A. Edelman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Catherine Baldus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. Harry K. Shock

(Address) 1204 E Eager St

15 Filed AUG 18 1920 19 ..... Registrar

Burial Permit Obtained

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 16 1920

17

I HEREBY CERTIFY, That I attended deceased from June 15 1920, to Aug 16 1920.

that I last saw her alive on Aug 16 1920.

and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tubercular Septicaemia (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? 1204 E Eager St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) James M Fenlon, M. D.

8/17 19 (Address) 700 E Clare St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug. 19 1920
20 UNDERTAKER Henry Horck Son	ADDRESS 1301 E Eager St

D45794 HEALTH DEPARTMENT—CITY OF BALTIMORE D45794

CERTIFICATE OF DEATH.

REGISTERED No. C 174

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital St. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence E. Raikes

(Residence in Baltimore: No. 429 W Conway St. 28 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... Don't Know ....., 1892
(Month) (Day) (Year)

7-AGE, 28 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Odd

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Chas. E Raikes

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Anna Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Raikes

(Address) 429 W. Conway St

15- Filed AUG 18 1920, 191.... ROBERT P. POOLE Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... August ..... 16..., 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fx. Basilar Brain Hemorrhage Complete
Prod. Compound Fracture R. Tibia
(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Accident
(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) M K Gorsuch M. D.
(Coroner.)

8-17..., 1920 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Aug. 19 1920

20-UNDERTAKER John H. Toadvine — ADDRESS 142 W. Pratt St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

1045795

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045795

CERTIFICATE OF DEATH.

REGISTERED No. C 1045

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 N Eden, St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Gittings

(Residence in Baltimore: No. 211 N Eden St. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec 29, 1919. (Month) (Day) (Year)

7-AGE, ... yrs. 7 mos. 21 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Ramiga Gittings

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Willie Pender

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ramiga Gittings

(Address) 211 N Eden St

15- Filed AUG 18 1920, 191.....

ROBERT P. KRAUTER
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 17, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 11 1920, to Aug 17 1920, that I saw h[illegible] alive on Aug 16 1920, and that death occurred, on the date stated above, at 6 Am.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) ..... yrs. ..... mos. 25 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Dr. Adolph L. Eisenberg M.D.

Aug 17, 1920 (Address) 1201 Orleans St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury

DATE OF BURIAL, Aug 18, 1920

20-UNDERTAKER John W Henderson

ADDRESS 1502 E Monument

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46796 HEALTH DEPARTMENT—CITY OF BALTIMORE D-45796

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward H. Smith

(a) RESIDENCE. No. 321 Forest ST., WARD. New Jersey

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lobster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant (Address) Bay View Hosp. Balto, Md.

15 Filed AUG 18 1920 ROBERT F. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1920. to Aug. 17, 1920.

that I last saw him alive on Aug 17, 1920.

and that death occurred, on the date stated above, at 12.05 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pancreahgrastrus Hemorrhagic Peritonitis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

8/17/20 (Signed) H. H. Edwards, M. D.

(Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	Aug 18 1920
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

TION is very important. See instructions

D45797 HEALTH DEPARTMENT—CITY OF BALTIMORE D45797

CERTIFICATE OF DEATH.

6100

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 526 Dolphin St.; 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. (8.))

2-FULL NAME Mary S. Mapp

(Residence in Baltimore: No. 526 Dolphin St. St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	Black	Single

6-DATE OF BIRTH, August 5, 1900
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
20 yrs. mos. 11 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Mapp

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Leah Barckley

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leah Mapp

(Address) 162 Denig Hill Ave

15- AUG 18 1920 191... ROBERT F. KRAUTER Registrar.
Filed

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 16, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epidemic Cerebrospinal Menin gitis.

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) ~~was~~ history

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

August 17 1920 (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Westminster Md	Aug 18 1920
20-UNDERTAKER	ADDRESS
Geo. H. Holland	1631 Ormond Ave

CAUSE OF DEATH important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045798 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045798

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1910 E Fayette St.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A Maxwell

(a) RESIDENCE. NO. 1910 E Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Harry Maxwell

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Lena Schroder

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Harry Maxwell (Address) 1910 E Fayette st

15 Filed AUG 18 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-17-20. 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 3rd, 1920, to Aug 17, 1920, that I last saw h alive on Aug 17, 1920, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Summer Diarrhoea, 1

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Geo. Stephenson M.D.

8/18/20 (Address) 1528 E. Monument St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 18th 1920
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

2045799 HEALTH DEPARTMENT—CITY OF BALTIMORE 2045799

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie Berger

(a) RESIDENCE. No. Maryville Pa ST., WARD. Maryville Pa

(Usual place of abode) Intourist

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1 - 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Joseph Butler

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Strauch

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Hospital Record
(Address) J. H. H.

15 Filed AUG 18 1920 19 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1920

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1920, to Aug 18, 1920, that I last saw her alive on Aug 18, 1920, and that death occurred, on the date stated above, at 3:10 a m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Maryville Pa

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood sugar.

(Signed) Ann Peril Purdy, M. D.

(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Maryville Pa	Aug 18 1920
20 UNDERTAKER	ADDRESS
Geo M. Frill & Son	811 N Wolfe

CAUTION is very important. See instructions

Spec.—8-24-14—M. & T.—2000 Bks.

1045800 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045800

CERTIFICATE OF DEATH.

REGISTERED NO. C 99

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1934 Light St ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Combs.

(Residence in Baltimore: No. 1934 Light St. St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug 24, 1847. (Month) (Day) (Year)

7-AGE, 72 yrs. 11 mos. 22 da. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ...Wife.
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Virginia

PARENTS.

10-NAME OF FATHER. John Colson

11-BIRTHPLACE OF FATHER (State or Country). Fredericksburg Va.

12-MAIDEN NAME OF MOTHER Jane Mills.

13-BIRTHPLACE OF MOTHER (State or Country). Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Native Cannot.

(Address) 1934 Light St.

15- AUG 18 1920 ROBERT J. BRAUER

Filed ....., 191.... BURIAL PERMIT Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 15, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1920, to Aug 15 1920, that I saw her alive on Aug 14 1920, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(Duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) 2 yrs. mos. ds.

(Signed) [illegible] M. D.

Aug 17, 1920 (Address) 1340 S Chas

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, Aug 18, 1920.

20-UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light St.

Important. See instructions.

Blazek.

2045801 HEALTH DEPARTMENT—CITY OF BALTIMORE 2045801

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 169

CITY OF BALTIMORE (No. Rundel and Fremont ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Blazek

(Residence in Baltimore: No. 2514 E Madison St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 66 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiterman
(b) General nature of industry, business, or establishment in which employed (or employer): Hotel

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, James Blazek

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Blazek

(Address) 2514 E Madison

15- AUG 18 1920 ROBERT B. BRAUER

Filed ....., 191.. Burial Permit Issued

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest and thereon and from the evidence obtained by said Inquest, sustained the opinion that said deceased came to death on the day stated above.

(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Accidental Drowning

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry P. Ensor M. D.
(Coroner)

Aug 18, 1920. (Address) 1800 E Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cem	Aug 19 1920
20-UNDERTAKER	ADDRESS
Margaret A. Flynn	1422 Light St.

CAUSE OF DEATH must be stated in plain terms. Indefinite or unsatisfactory answers will not be accepted. Every question must be answered if possible. Omissions will cause unnecessary correspondence. Please write plainly and with ink. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6045802 6045802

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 N. Wolfe ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine C. Roberts

(a) RESIDENCE. No. 420 N. Wolfe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? 76 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Wm B. Roberts

6 DATE OF BIRTH (month, day, and year) Sept 21-39

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Wilson Roberts (Address) 420 N. Wolfe St

15 Filed AUG 18 1920 ROBERT F. FAIRBANK Registrar Burial Permit Clerk

TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1920, to Aug 16, 1920, that I last saw her alive on Aug 16, 1920, and that death occurred, on the date stated above, at 9:15 A m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Leavell M. D.

8/17, 1920 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	Aug 19 1920
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

045803 HEALTH DEPARTMENT—CITY OF BALTIMORE 045803

CERTIFICATE OF DEATH.

175-03

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital ST. 12 WARD)
REGISTERED No. C.....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Bean

(Residence in Baltimore: No. 431 E. North Ave. St.; 16 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	~~Single~~

6-DATE OF BIRTH. June 17, 1896 (Month) (Day) (Year)

7-AGE, 24 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brakeman
(b) General nature of industry, business, or establishment in which employed (or employer): Pa R.R. Co

9-BIRTHPLACE, (State or Country): Rockford Virginia

PARENTS.

10-NAME OF FATHER. Robert L. Bean

11-BIRTHPLACE OF FATHER (State or Country). Charleston W. Va

12-MAIDEN NAME OF MOTHER. Elizal Cook

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Forrest L. Bean
(Address) 431 E. North ave

15-
Filed AUG 18 1920, 191.... ROBERT B. [illegible] Registrar.

CAUSE OF DEATH must be filled in. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 17, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an [illegible] (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said [illegible] (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism received by R.R. employee

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. Wm. Luckey M. D.
8-18 1920 (Coroner.) (Address) Canton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Elkridge M. E	Aug 20, 1920
20-UNDERTAKER William Cook	ADDRESS 502 E. North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45804 HEALTH DEPARTMENT—CITY OF BALTIMORE 79 D45804

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 160 N. Hare ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie F. Helfer

(a) RESIDENCE. NO. 124 S. Ann ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late John B. Helfer

6 DATE OF BIRTH (month, day, and year) June 12-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co Md

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) A. A. Co Md.

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co. Md

14 Informant Lillian E. Cuneo (Address) 160 N. Hare St.

15 Filed AUG 18 1920 ROBERT P. LAZENBY Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17- 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 16 .20. to Aug. 18 .20.

that I last saw her alive on Aug 17 . 1920.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Wirt Insley M. D.

, 19 (Address) 2958 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Aug. 20- 1920
20 UNDERTAKER William Cook	ADDRESS 1027 E North Ave

TION IS very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 1227

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Schultz

(a) RESIDENCE. No. York Howard 2nd ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. 0 mos. 0 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Schultz

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 77 Years Months about Days

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record (Address) J. H. H.

15 Filed AUG 13 1920 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1920 to Aug 17, 1920, that I last saw h.. alive on Aug 17, 1920, and that death occurred, on the date stated above, at 12:50 P.M.

The CAUSE OF DEATH* was as follows:

Lipoid nephritis.

Prostatic hypertrophy.

(duration 3 weeks) ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) H. H. Hartley, M. D.

Aug. 17, 1920 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: Aug 19 1920

20 UNDERTAKER: William Faelgowski

ADDRESS: 1611 E. ...

TION IS VERY IMPORTANT.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045806 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045806

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp'l ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James May

(a) RESIDENCE. No. R.F.D. Box 72 Greenville S.C. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence May

6 DATE OF BIRTH (month, day, and year) July 17 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Photographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) S. C. (State or country)

PARENTS

10 NAME OF FATHER Wm. May

11 BIRTHPLACE OF FATHER (city or town) Georgia (State or country)

12 MAIDEN NAME OF MOTHER Marie O'Barney

13 BIRTHPLACE OF MOTHER (city or town) S. C. (State or country)

14 Informant Hospital Record J. H. H. (Address)

15 Filed AUG 18 1920 ROBERT F. HEALTEY Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1920, to Aug 15, 1920, that I last saw h.... alive on Aug 15, 1920, and that death occurred, on the date stated above, at 6:20 a.m.

The CAUSE OF DEATH* was as follows:

Brain tumor

About 2 yrs. mos. ds. (duration)

CONTRIBUTORY (Secondary) Operation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8/17/20

Was there an autopsy? yes

What test confirmed diagnosis? P.M.

(Signed) W C Huyler, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenville S C

DATE OF BURIAL Aug 18 1920

20 UNDERTAKER Joseph Ahrens

ADDRESS 221 N Bway

CAUSES OF DEATH. SPECIAL ATTENTION is very important. See instructions on reverse side.

Spec.—6-9-19—H. P. Co.—1000 Bks.

045807 HEALTH DEPARTMENT—CITY OF BALTIMORE 045807

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. St.: 15 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Agnes Gibbons

(a) RESIDENCE. No. 3755 Reisterstown Rd. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) Nov. 16. 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Peter J. Gibbons

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Catherine Reddington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Record: Mercy Hospital (Address)

15 Filed AUG 18 1920 16 LOVERY & KRAUTER Registrar Bureau Vital Statistics

TION is very important. See instructions on reverse side.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 9, 19 20, to Aug 17, 19 20

that I last saw her alive on Aug. 16, 19 20,

and that death occurred, on the date stated above, at 1.30 m.

The CAUSE OF DEATH* was as follows:

Supra Vaginal Hyster-
ectomy done Aug 10 '20
Uterine Fibroids
6 (duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism
Pul Embolism (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 10 '20

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) D. J. Pessagno, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cy,	Aug 20 1920

20 UNDERTAKER C. Molan ADDRESS 3000 E Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045808

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045808

CERTIFICATE OF DEATH.

29

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2114 E Madison ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Zamrzla

(a) RESIDENCE. NO. 2114 E Madison ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Zamrzla

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 77; Months; Days; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lubowec Bohemia

PARENTS

10 NAME OF FATHER: Antonin Machon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Anna Zamrzla

(Address): 2114 E Madison St

15 Filed AUG 18 1920 ROBERT T. KRAUTER Registrar

Burial Permit Issued

TION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 15 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 15th, 1920, to Aug 15th 1920, that I last saw her alive on Aug 15th 1920, and that death occurred, on the date stated above, at 1145 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. Siegmund M.D.

, 19 (Address) 2528 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Aug 19 1920

20 UNDERTAKER: Frank Brack & Son — ADDRESS: 1806 Gold

Spec. 6-9-19 H. P. Co.—1000 Bks.

1045809 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045809

CERTIFICATE OF DEATH. 104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3926 Foster Ave ST. 26 WARD)

2-FULL NAME Joseph M. Regan.

(a) RESIDENCE. NO. 3926 Foster Ave ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 11 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 10th 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General natore of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph M. Regan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co. Md.

12 MAIDEN NAME OF MOTHER Annetta M. Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) Joseph M. Regan. 3926 Foster Ave.

15 Filed AUG 18 1920 19 ROBERT P. BRUTER Registrar Burial Permit Clerk

TION is very important. See instructions.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 16. 1920. to Aug 17. 1920.
that I last saw him alive on Aug 16. 1920.
and that death occurred, on the date stated above, at 7 30 a.m.
The CAUSE OF DEATH* was as follows:

Acute Enteritis (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? —
What test confirmed diagnosis? —

(Signed) mfs McAvoy, M. D.
8/18, 1920 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Solcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Aug 19th 1920
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045810 — 172 1045810

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 1514 Division St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin Bennett

(Residence in Baltimore: No. 1429 Myrtle Avenue St.; 46 yrs., mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, August (Month) 10 (Day), 1874 (Year)

7-AGE, 46 yrs. 6 mos. 6 ds. — If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bar-tender
(b) General nature of industry, business, or establishment in which employed (or employer): Hotel

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George Bennett

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Hunt

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thetelen M. Bennett

(Address) Magnolia, Harford Co. Md.

15- AUG 18 1920 Filed, 191.... ROBERT P. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 12 1920, to August 16 1920, that I saw h[illegible] alive on August 16 1920, and that death occurred, on the date stated above, at 11 55 A.m.

The CAUSE OF DEATH* was as follows:

Fracture of left humerus

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Delirium Tremens

(Duration) yrs. mos. 1 ds.

(Signed) T. N. Jamison M. D.

Aug 16, 1920 (Address) 4 W. N.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 5 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence 1429 Myrtle ave, Balto Md

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Balto Cemt	Aug 19, 1920
20-UNDERTAKER	ADDRESS
Lilly Zeiler	403 So Wolfe

(over)

Spec.—6-9-19—H. P. Co.—1000 Bks.

10.45811

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.45811

105

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Hosp. ST.: 9 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A Kennedy (MARGARET KENNADY)

(a) RESIDENCE. NO. 4013 Greenmount Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
White	Female	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Asheville North Carolina

PARENTS

10 NAME OF FATHER Chas. S. Kennedy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky

12 MAIDEN NAME OF MOTHER Elenor Dearing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky

14 Informant Charles S. Kennedy (Address) 4013 Greenmount Ave.

15 Filed 8 18 1920 Robert P. Harrison, Burial Permit Clerk. Registrar

TION is very important. See that

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/18 1920

17 I HEREBY CERTIFY, That I attended deceased from 8/11, 1920, to 8/18, 1920, that I last saw h alive on 8/18, 1920, and that death occurred, on the date stated above, at 2.30 a m.

The CAUSE OF DEATH* was as follows:

Acute Entero-Colitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lewis O. Padgett M. D

8/18 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 8/19 1920

20 UNDERTAKER Henry W. Maus & Son

ADDRESS 805 N. Calvert St

Spec.—6-3-19—H. P. Co.—1000 Bks.

0.45812 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.45812

104 ✓

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2053 Woodberry Ave ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle Elizabeth Day

(a) RESIDENCE. No. 2053 Woodberry Ave ST.. 13 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 6 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 22. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER Roy A. Day

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Fannie M. Clements

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Roy A. Day

(Address)

Filed AUG 18 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 14th 1920. to Aug 17th 1920. that I last saw h[er] alive on Aug 16th 1920. and that death occurred, on the date stated above, at 7 10 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Aug 18 1920 W. A. Fair M. D.

(Address) 17 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	Aug. 20 1920
20 UNDERTAKER Horace Burgee & Son	ADDRESS 3631 Falls Rd.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.45813 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45813

28v

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 Hollington St. ST.; 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie G. Brown

(a) RESIDENCE. No. 803 Hollington St ST., 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 9 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 24-1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady 067

(b) General nature of industry, business, or establishment in which employed (or employer) Department Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm. H. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Annie G. Perkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D. C.

14 Informant Wm. H. Brown

(Address) 803 Hollington St.

15 Filed AUG 18 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important. See that

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1920, to Aug 16, 1920, that I last saw h— alive on Aug 16 and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis.

Apparently (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Few remarks

What test confirmed diagnosis? General Symptoms

(Signed) E. B. Vermont, M. D.

19 (Address) 3847 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Aug. 19 1920
20 UNDERTAKER Horace Burgee & Son	ADDRESS 3631 Falls Rd

D.45814 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45814

CERTIFICATE OF DEATH.

1821

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1209 E Hollins ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marcellus Reynolds 31 yrs.

(Residence in Baltimore: No. 1209 Hollins St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ..., (Month) 1 (Day) ..... (Year)

7-AGE,	If LESS than 1 day,
40 yrs. ..... mos. ..... ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Photographer
(b) General nature of industry, business, or establishment in which employed (or employer): Privately

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER, J. Benjamin Reynolds

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country), ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marguart T Reynolds

(Address) 1209 Hollins St.

15- Filed ..... 191..... Robert F Harrison, Registrar.

AUG 18 1920 Burial Permit Clerk

N.B.—Every item of information should be carefully considered, and the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows: Bullet wound - Brain & Liver by Police Officer in performance of duty (Duration) 2 hrs. ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James H Hundley M. D. (Coroner.)

Aug 16, 1920 (Address) 200 E Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Aug. 19, 1920
20-UNDERTAKER	**ADDRESS**
Richard H. Lemley	410 Barclay St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45815

45815

CERTIFICATE OF DEATH.

REGISTERED NO. C 137

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 N Price St ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Miles

(Residence in Baltimore: No. 612 N Price St St.; ..... yrs., 3 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 23 (Day), 1903 (Year)

7-AGE, 17 yrs. ..... mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Wye mills Talbot Co

PARENTS.

10-NAME OF FATHER, Geo. W. Miles

11-BIRTHPLACE OF FATHER (State or Country) Balto. Md

12-MAIDEN NAME OF MOTHER Carrie Abbott

13-BIRTHPLACE OF MOTHER (State or Country) Easton Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Abbott

(Address) Wye mills Talbott Co Md

15-

AUG 18 1920

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 17th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15th 1920, to Aug 17th 1920, that I saw her alive on Aug 17th 1920, and that death occurred, on the date stated above, at 5:05 P.m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicaemia

(Duration) ..... yrs. about 4 mos. ..... ds.

CONTRIBUTORY (Secondary) (Forceps)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. L. Hammett M. D.

Aug 17th 1920 (Address) 1929 Edmondson Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 3 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Wye Mills

Former or usual residence Talbott Co

19-PLACE OF BURIAL OR REMOVAL, Wye mills Talbot Co

DATE OF BURIAL. Aug 19, 1920

20-UNDERTAKER William G Schaffer

ADDRESS 1816 Maryland

Fill out all items if important. See instructions on back.

L

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45816 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45816

CERTIFICATE OF DEATH. 120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1228 Etting ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Burke

(a) RESIDENCE. NO. 1228 Etting ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lydia Burke

6 DATE OF BIRTH (month, day, and year) Unknown 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 873

(b) General nature of Industry, business, or establishment in which employed (or employer) Pa. R.R. Co.

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Lydia Burke (Address) 1228 Etting Street

15 Filed AUG 18 1920 Robert P. Harrison, Registrar

(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17 1920

17 I HEREBY CERTIFY, That I attended deceased from 4/17, 1920, to 8/17, 1920, that I last saw him alive on 8/17, 1920, and that death occurred, on the date stated above, at 1:10 P m.

The CAUSE OF DEATH* was as follows:

Uremia

Chronic (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Parenchymatous Nephritis (duration) yrs. 6 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. A. Pohlmann, M. D.

8/18, 1920 (Address) 1019 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Aug 19 1920
20 UNDERTAKER John M. Johnson	ADDRESS 1237 Etting St.

TION is very important. See instructions on back.

045817 HEALTH DEPARTMENT--CITY OF BALTIMORE 045817

CERTIFICATE OF DEATH

10

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1514 W Pratt St St. 14 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Doris M. Ebberts

(Residence in Baltimore: No. 1514 W Pratt St St.: yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: May (Month) 25 (Day), 1920 (Year)

7 AGE: yrs. 4 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto

PARENTS

10 NAME OF FATHER: Stanley Place

11 BIRTHPLACE OF FATHER (State or country): New York

12 MAIDEN NAME OF MOTHER: Ida Ebberts

13 BIRTHPLACE OF MOTHER (State or country): Balto

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ida Ebberts

(Address) 1514 W Pratt St

15 Filed AUG 19 1920, 191 [illegible] Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug (Month) 18 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1920, to Aug 18 1920, that I saw h[illegible] alive on Aug 17, 1920, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

acute Entero Colitis

(Duration) yrs. mos. 5 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) P Gustav Boie M. D.

Aug 18, 1920 (Address) 1433 W Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Western

DATE OF BURIAL: Aug 20, 1920

20 UNDERTAKER: John J Fields

ADDRESS: 1205 W Fayette

State CAUSE OF DEATH in plain terms. Do not use abbreviations or initials. Name of contagious disease is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

045818

HEALTH DEPARTMENT—CITY OF BALTIMORE

045818

151

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2700 Harlem Av St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Melton Walker

(Residence in Baltimore: No. 2700 Harlem Av St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Aug 18, 1912
(Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 4 hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balt.

PARENTS.

10-NAME OF FATHER. Edward Walker

11-BIRTHPLACE OF FATHER (State or Country). Balt

12-MAIDEN NAME OF MOTHER Mabel Harlan

13-BIRTHPLACE OF MOTHER (State or Country). Balt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M. Walker

(Address) 2700 Harlem

15-
Filed AUG 19 1920, 191.... ROBERT E LEUTER
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 18, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 18 1920, to Aug 18 1920, that I saw h... alive on Aug 18 1920, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular
of 7 to Month
(Duration) ....yrs....mos....ds.

CONTRIBUTORY
(Secondary)
(Duration) ....yrs....mos....ds.

(Signed) Howard W Jones M. D.

Aug 18 1920 (Address) 722 Edgevale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Aug 19, 1920
20-UNDERTAKER	**ADDRESS**
J Berry Fields	1200 W Lombard

Spec.—6-9-19—H. P. Co.—1000 Blks.

1045819

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045819

CERTIFICATE OF DEATH.

40

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 603 Sharp St. ST.: 27 WARD)

2-FULL NAME Edward Miller

(a) RESIDENCE. NO. 603 Sharp ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Blk | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Miller

6 DATE OF BIRTH (month, day, and year) DEC. 20 - 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steward

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: J. Miller (Address): 603 Sharp St

15 Filed AUG 19 1920 ROBERT [illegible] Registrar

BUREAU PERMIT CLERK

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1920

I HEREBY CERTIFY, that I attended deceased, from June 16, 1920, to Aug 16, 1920

that I last saw him alive on Aug 14, 1920.

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What tests confirmed diagnosis?

(Signed) [signature] M. D.

(Address) 1120 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 19 1920
20 UNDERTAKER	ADDRESS
L. L. Dennis & Son	1615 W Mulberry

c.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

No 45820

45820

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1133 Light St (St.) 23 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph V. Weber

(a) RESIDENCE (No.) 1133 Light St (St.) (Ward.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred (yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

If ~~married~~ widowed, or ~~divorced~~ HUSBAND of (or ~~WIFE~~ of) Anna Weber.

DATE OF BIRTH (month, day, and year) Nov 10 1857

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	9	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker Business

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Andrew Weber.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary N. Krauz.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

PARENTS

14 Informant Annie Weber. (Address) 1133 Light St.

15 Filed ..... 19 ..... Registrar

AUG 19 1920 ROBERT [illegible]

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 16 1920

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1920, to aug 16, 1920, that I last saw h[illegible] alive on aug 16, 1920, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Mitral insufficiency

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No retrograde test

What test confirmed diagnosis? albuminuria

(Signed) J. O'Donnell M. D.

, 19 (Address) 107 E West St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A&C	Aug. 19 1920

20 UNDERTAKER E and B Earle

ADDRESS 115 E West St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045821

1045821

113

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 945 N Chester ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John E Donnell

(Residence in Baltimore: No. 945 N chester st St.; 77 yrs., 1 mos. 10 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, 7 July, 1843. (Month) (Day) (Year)

7-AGE, 77 yrs. 1 mos. 10 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Paper Hanger
(b) General nature of industry, business, or establishment in which employed (or employer): 57

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Donnell

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Emily Mills

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Donnell

(Address) 945 N. Chester

15- AUG 19 1920 ROBERT P. KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 17, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1920, to Aug 17 1920, that I saw h[illegible] alive on Aug 17 1920, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Gen

(Duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. mos. da.

(Signed) Edward Lee M. D.

8/18, 1920 (Address) 416 N Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, National Cemetery

DATE OF BURIAL, Aug 20, 1920

20-UNDERTAKER Chas C. Mueller

ADDRESS 2334 Jefferson St

D. 45822 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 45822

CERTIFICATE OF DEATH.

1692

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE (No. Off Baltimore Dry Docks. ST.: 1 WARD) (Locust Point)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hodges Bonnett. 20 ------- 28.

(Residence in Baltimore: No. 513 S. Linwood Ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH. July 19th, 1900. (Month) (Day) 1 (Year)

7-AGE. 20 yrs. --- mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Deckhand on tug.
(b) General nature of industry, business, or establishment in which employed (or employer)..... Esther Phillip.

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER. John Bonnett.

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER Margaret Hodges.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Le Compt, (mother)

(Address) 513 S. Linwood Ave.

15- Filed AUG 19 1920, 191..... Robert P. Waltman, Registrar.

Burial Permit Clerk.

Cross out words not important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 16th, 1920.
Found floating August 18th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Accidental fall from tug.

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Aug. 19th, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem	Aug 19. 1920
20-UNDERTAKER	ADDRESS
H Sander & Son	710 Fleet St

D.45823

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45823

CERTIFICATE OF DEATH.

175

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ~~Hospital~~ 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Lehr

(Residence in Baltimore, No. 417 N Streeper St. St. (yrs. 37 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, October 13, 1867
(Month) (Day) (Year)

7-AGE, 52 yrs. 10 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Business Agent
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, George Lehr.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Mary Seibert.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie Lehr

(Address) 417 N. Streeper St.

15-

Filed AUG 19 1920, 191....

Robert P Harrison,
Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH ..... August 16, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Shock by Acute (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ..... (Duration) ....yrs....mos....ds.

(Signed) J. Wirt Insley M. D.
(Coroner)

8-18 1920 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL, Aug 19, 1920

20-UNDERTAKER Geo Lenhardt & Son

ADDRESS 647 W Baltimore St

Coroner's certificate must be filled out. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 45824 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 45824

CERTIFICATE OF DEATH. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hosp. (St.) 24 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Zahra Riley

(a) RESIDENCE. No. 729 Mc Henry St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. 1 ds. How long in U. S., if of foreign birth? 30 yrs. ~ mos. ~ ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Riley

6 DATE OF BIRTH (month, day, and year) March 12, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	42	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John Riley (Address) 729 McHenry

15 Filed AUG 9 1920 19 Robert P. Harrison Registrar

Burial Permit Clerk.

TION is very important. Use

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/18 1920

17 I HEREBY CERTIFY, That I attended deceased from 8/13 1920 to 8/18 1920 that I last saw h alive on Aug. 18, 1920 and that death occurred, on the date stated above, at 2.05 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Simon D. Rodgers, M. D.

8/18 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug 21 1920
20 UNDERTAKER	ADDRESS
Geo Lemlach & Son	6 Cornhill

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45825 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45825

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 S Sharp St. 22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Carpenter

(a) RESIDENCE. No. 816 S Sharp St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 3 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Col | 5 Single, Married, Widowed, or Divorced (write the word): married.

5a If married, widowed, or divorced (or) WIFE of: Robert Carpenter

6 DATE OF BIRTH (month, day, and year): May 7, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self - Baltimore

9 BIRTHPLACE (city or town) (State or country): Maryland,

PARENTS

10 NAME OF FATHER: Charles Harborough

11 BIRTHPLACE OF FATHER (city or town) (State or country): Crisfield Maryland

12 MAIDEN NAME OF MOTHER: Amelia Milburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Amelia Miller
(Address): 816 S Sharp

15 Filed ... Robert P Harrison, Registrar

OCT 9 1920

Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/17 1920

17

I HEREBY CERTIFY, That I attended deceased from 4/15, 1920, to 8/17, 1920, that I last saw her alive on 8/17, 1920, and that death occurred, on the date stated above, at 9.10 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Consultation

(Signed) Wm Francklin M. D.

(Address) 8/18/1920 1226 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Aug 20 1920
20 UNDERTAKER	**ADDRESS**
Sam'l M. Cluse Son	1400 Mosher

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45826 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45826

CERTIFICATE OF DEATH.

REGISTERED NO. 792

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 Bolton ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett Ann Parsons

(a) RESIDENCE. NO. 1814 Bolton ST., 14 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ? mos. ? ds. How long in U. S., If of foreign birth? 83 yrs. 3 mos. 30 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon Parsons

6 DATE OF BIRTH (month, day, and year) April-18-1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	3	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Frederick City- Maryland

PARENTS

10 NAME OF FATHER Saml R. Hogg

11 BIRTHPLACE OF FATHER (city or town) Wilmington (State or country) Delaware.

12 MAIDEN NAME OF MOTHER Rachael Bouldin

13 BIRTHPLACE OF MOTHER (city or town) Elkton (State or country) Cecil Co. Maryland

14 Informant Mr. Arthur Parson- (son) (Address) 1814 Bolton St.

15 Filed AUG 18 1920, 19 Robert J. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1920 - 8-17 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 15, 1920, to Aug 17, 1920, that I last saw her alive on Aug 17 -, 1920, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Arteria - Sclerosis -

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Mitral insufficiency-

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Auscultation & Percussion

(Signed) John J. Young, M. D.

Aug. 18 1920 (Address) 1425 Eutaw Pl -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Aug-19/ 1920

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE

TION IS very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45827

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45827

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1009 Linden Av ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Frazier

(Residence in Baltimore: No. 1009 Linden Ave St.; 65 yrs., ~~65~~ mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male.

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED? (Write the word.) Married

6-DATE OF BIRTH, unknown, 1855
(Month) (Day) (Year)

7-AGE, 65 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Waiter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harris Frazier

(Address) 1009 Linden Ave

15- Robert P Harrison,

Filed....., 191.... Burial Permit Clerk.....
Registrar.

AUG 19 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 17th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1920, to Aug 17th 1920, that I saw h[illegible] alive on Aug 16th 1920, and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Diabetes

..... (Duration) yrs. mos. 2 ds.

(Signed) Dr Mitch M. D.

Aug 17th, 1920 (Address) 607 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn

DATE OF BURIAL, Aug 21, 1920

20-UNDERTAKER Daniel Easton

ADDRESS 916 Penna Ave

D. 45828 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45828

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 522 Gold (St.: 14 WARD)

REGISTERED No. C 1049

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thornton Malony Carter

(Residence in Baltimore: No. 522 Gold St. St.; 22 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	black	married

6-DATE OF BIRTH, November (Month) (Day), 1882 (Year)

7-AGE, 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Hod carrier
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Virginia

PARENTS.

10-NAME OF FATHER, Manuel Carter

11-BIRTHPLACE OF FATHER (State or Country) Virginia

12-MAIDEN NAME OF MOTHER Ellen Malony

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert F. Carter

(Address) 522 Gold St.

15- Robert F. Harrison,

Filed ....., 191.....

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inq (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Contusion

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(Duration) yrs. mos. 2 ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

August 16 1920 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Aug. 19. 1920
20-UNDERTAKER,	ADDRESS
Edw. Ruggold	1463 Carey St

AUG 19 1920

important. See instructions on back of Certificate

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45829 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45829

154

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1913 W. Mulberry ST.: 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Johannes

(a) RESIDENCE. NO. 1913 W. Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of Henry Johannes

6 DATE OF BIRTH (month, day, and year) 8. 27. 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... mln.
	84	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Hurkamp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm. Johannes
(Address) 1913 W. Mulberry st.

15 Filed AUG 19 1920 Robert J. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8. 17. 1920.

17 I HEREBY CERTIFY, That I attended deceased from August 10 = 1920, to August 17 = 1920.

that I last saw her alive on August 17 = 1920,

and that death occurred, on the date stated above, at 11 ½ A m.

The CAUSE OF DEATH* was as follows:

Infirmities of Old Age

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Excessive Heat

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

8/17, 1920 (Signed) Charles A. Meyer, M. D.
(Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Aug 20 1920
20 UNDERTAKER	ADDRESS
Martin Faber & Sons	1527 W North Av

TION is very important. See instructions

D. 45830 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 45830

Bay View Hosp. 1822

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balto Co REGISTERED No. C

CITY OF BALTIMORE (No. Shelltop Ave ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas O'Neil

(Residence in Baltimore: No. 930 Bennett Place St.; yrs., 78 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED or DIVORCED (If you write the word.) Widower

6-DATE OF BIRTH, ..., 1842
(Month) (Day) (Year)

7-AGE, 78 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired Grocer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER, William O'Neil

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Mary L. Hayes

13-BIRTHPLACE OF MOTHER (State or Country) Allegheny Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Eulrich

(Address) 930 Bennett Place

15-

Filed ..... 1911 Robert T. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 16, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicidal Shooting by Husband

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas Ryan Omalley M. D.
(Coroner)

Aug 19, 1920 (Address) 1054 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge — DATE OF BURIAL, Aug 20, 1920

20-UNDERTAKER Martin Eakes Son — ADDRESS 1237 W Northern

AUG 19 1920

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

0.45831 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.45831

CERTIFICATE OF DEATH.

REGISTERED NO. C 792

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U. S. P. H. S. Hospital #56 St.; 17 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hurdy Purifoy

(Residence in Baltimore: No. 743 George St., Baltimore, Md. St.: unknown yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Divorced

6-DATE OF BIRTH, Unknown (Month), 1 (Day), ... (Year)

7-AGE,	If LESS than 1 day,
32 yrs. --- mos. --- ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Georgia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E.T. Rambrook Reporter

(Address) Fort McHenry, Balto. Md.

15- Filed Aug 19 1920, 191.... Robert P. Harrison, Registrar.
Burial Permit Cl...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 16, 1920 (Month) (Day) (Year), 191...

17- I HEREBY CERTIFY, That I attended deceased from August 15 1920, to August 16 1920, that I saw him alive on August 16 1920, and that death occurred, on the date stated above, 6:45 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thomas B. Payne M. D.

Aug 17, 1920 (Address) Fort McHenry, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death --- yrs. --- mos. 2 ds. In the State Md --- yrs. --- mos. 2 ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 743 George St., Baltimore, Md

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL.
Milledgeville Ga	Aug 19, 1920
20-UNDERTAKER	ADDRESS 1127 E
S. Leonard Berg	Balto st

Spec.—8-24-14—M. & T.—2000 Bks.

D45832

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45832

CERTIFICATE OF DEATH.

28

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 S Pulaski St.; '20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Catherine Koch

(Residence in Baltimore: No. 414 S Pulaski St. St., 18 yrs., 5 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. February 2, 1902 (Month) (Day) (Year)

7-AGE. 18 yrs. 5 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Martin Koch

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Catherine Steigler

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Martin Koch

(Address)..... 414 S. Pulaski St

15- AUG 19 1920 ROBERT P. KRAUTER Registrar.
Filed....., 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. August 18, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 10 1919, to Aug 18 1920, that I saw h[illegible] alive on Aug 18 1920, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Ulcerations yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

Ulcerations yrs. mos. ds.

(Signed) Norbert C. Myles M. D.

Aug 18, 1920 (Address) 2151 Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Olivet Cemetery

DATE OF BURIAL. Aug 20th, 1920

20-UNDERTAKER C. B. Whitehead

ADDRESS 2336 Frederick Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 1045833

1045833

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2014 Robb ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary V. MacCubbin

(a) RESIDENCE. NO. 2014 Robb ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard W. MacCubbin aug 8-1883

6 DATE OF BIRTH (month, day, and year)	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
7 AGE	65	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER William Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Jemima Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Harry C. MacCubbin (Address) 3913 Clifton ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18 1920

17 I HEREBY CERTIFY, That I attended deceased from July 25 1920 to Aug 18 1920

that I last saw her alive on Aug 17 1920 8.30 a. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) General Metastasis

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John Gorsuch, M. D.

(Address) 936 E Monument St.

Aug 18 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet

20 UNDERTAKER Wm Cook

DATE OF BURIAL aug 21 1920

ADDRESS 902 E. North ave.

TION IS VERY IMPORTANT

AUG 23 1920 ROBERT E. LAZENBY

Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045834

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045834

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Manns

(a) RESIDENCE. NO. 926 Bolton St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	black	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 21, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.J. Jersey City.

PARENTS

10 NAME OF FATHER Edward Manns.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Hospital Records.
(Address)

15 Filed AUG 19 1920 ROBERT P. LEMMON Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 8th, 1920, to August 18, 1920, that I last saw her alive on August 18th, 1920, and that death occurred, on the date stated above, at 4.40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. Lumsey, M. D.

8/19 1920 (Address) Bay View Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Aug 21-1920
20 UNDERTAKER William Cook	ADDRESS 502 E. North ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045835 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045835

CERTIFICATE OF DEATH. 29

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital, Bay View WARD 18)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wodinsky

(a) RESIDENCE. NO. ? 846 N Lombard St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Europe (Poland?)

PARENTS

10 NAME OF FATHER Simon Walinsky

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Rose Gracky

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Lithuania

14 Informant Records

(Address) City Hospital, Bay View

15 Filed ..... 19.... Registrar

THIS IS VERY IMPORTANT

AUG 19 1920 BOWERY X YEATES

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17, 1920

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1920, to Aug. 17, 1920, that I last saw h.. alive on Aug. 17, 1920, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of upper jaw

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of at another Hospital.

Was there an autopsy? Yes.

What test confirmed diagnosis? Microscopic

(Signed) Wm Stearman, M. D.

Aug 17, 1920 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Aug 20 1920
20 UNDERTAKER	ADDRESS
John Gethmann & Son	1425 E. Pratt St.

Spec.—5-19-13—M. & T.—500 Bks.

0945836 HEALTH DEPARTMENT—CITY OF BALTIMORE 0945836

CERTIFICATE OF DEATH.

104

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 Riley Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Garner

(Residence in Baltimore: No. 26 Riley Ave St.; ....yrs., 11 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	black	Single

6-DATE OF BIRTH, August (Month) 21 (Day), 1915 (Year)

7-AGE,	If LESS than 1 day,
....yrs. 11 mos. 27 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country) Mt Washington Md

PARENTS.

10-NAME OF FATHER, Clyde C. Garner

11-BIRTHPLACE OF FATHER (State or Country), Mt Washington Md

12-MAIDEN NAME OF MOTHER Ruth Wicks

13-BIRTHPLACE OF MOTHER (State or Country), Mt Washington Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clyde C. Garner

(Address) 26 Riley Ave

15. AUG 19 1920 ROBERT F. STRAUSS Filed ....., 191.... BURIAL PERMIT Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 18 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 28 1920, to Aug 18 1920, that I saw her alive on Aug 17 1920, and that death occurred, on the date stated above, at 8.35 A.

The CAUSE OF DEATH* was as follows:

Carcinoma

(Duration) ....yrs. ....mos. 20 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. 4 mos. ....ds.

(Signed) Wilbur R. Ford M. D.

8/18, 1920 (Address) Mt Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Lebanon Long Green — DATE OF BURIAL, Aug 20 1920

20-UNDERTAKER Geo A Holland — ADDRESS 1631 Druid

Soine

1045837 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045837

CERTIFICATE OF DEATH. 159

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2419 Barkley ST. 12 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Sonne

(Residence in Baltimore: No. 2419 Barkley st St.; (yrs., 65 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M.	W.	Single

6-DATE OF BIRTH, June (Month) 22 (Day), 1855 (Year)

7-AGE, 64 yrs. 1 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Asst. Librarian
(b) General nature of industry, business, or establishment in which employed (or employer)..... City Hall

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER Georg. Sonne

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Ema. Segelken

13-BIRTHPLACE OF MOTHER (State or Country), Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma K. Sonne

(Address) 2419 Kinsman st

15- AUG 19 1920 ROBERT B KRUGER

Filed ..... 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gunshot wound
Strong, head
(Suicide)
(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)
(Duration) .....yrs.....mos.....ds.

(Signed) John H. Mueller M. D.
(Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
London Park Cemetery	August 20th 1920
20-UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

0.45838 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.45838

CERTIFICATE OF DEATH. 28

REGISTERED NO.

1-PLACE OF DEATH Municipal Tuberculosis Hospital

CITY OF BALTIMORE: (NO. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Maggie Mason

(a) RESIDENCE. NO. 763 Bradley ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED Chambermaid

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah Clifford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hospital Records

15 Filed AUG 19 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 15 1920

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1920, to August 15, 1920, that I last saw her alive on August 15, 1920, and that death occurred, on the date stated above, at 2:10 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Enteritis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tb. Bacilli in Sputum

(Signed) L. J. Rigney, M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19..

20 UNDERTAKER — ADDRESS

Commissioner of Health

UNIVERSITY OF MARYLAND

Spec.—8-24-14—M. & T.—2000 Blks.

D.45839 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45839

1720

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 24 E Heath St. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Lauer

(Residence in Baltimore: No. 24 E Heath St.; 28 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male — 4-COLOR OR RACE, White — 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June 28, 1892 (Month) (Day) (Year)

7-AGE, 28 yrs. 1 mos. 21 ds. — If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), ~~Baltimore~~ Germany.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Lauer.

(Address) 1600 Marshall st.

15- Robert P. Harrison,

AUG 19 1920

Filed....., 191.....

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 18 1920, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 10 1920, 191, to Aug 18 1920, 191, that I saw him alive on Aug 18 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

from history (Duration) 0 yrs. 6 mos. 0 ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) C. H. Washburn M. D.

Aug 19, 1920 (Address) 3100 Harford Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park. — DATE OF BURIAL, Aug. 21, 1920

20-UNDERTAKER J. Fred. McCully — ADDRESS 130 E. Fortau

Spec.—6-9-19—H. P. Co.—1000 Bks.

0.45840 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.45840

CERTIFICATE OF DEATH. 37

1-PLACE OF DEATH Bay View Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earnest Smith

(a) RESIDENCE. NO. 1328 N. Mount ST., WARD.
(Usual place of abode) Unknown (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Bayview Hospital Baltimore, Md.

15 Filed Aug 19 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1920, to Aug. 17, 1920, that I last saw him alive on Aug 17, 1920, and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Lues

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Serological

(Signed) N. H. Smith, M. D.

8/17/1920 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 21 1920

20 UNDERTAKER ADDRESS

Clement Hall 1945 Bruce ave

G 19 1920

D.45841 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45841

CERTIFICATE OF DEATH.

79v

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Camden Station city St.: 18 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Prof Jerman

(Residence in Baltimore: No. 209 N Carey St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Oct 10, 1838
(Month) (Day) (Year)

7-AGE, 81 yrs. 11 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joseph Jerman

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Walter S. Hull

(Address) 4715 Sunbeam Road

15- AUG 19 1920 Robert P. Harrison,
Filed....., 191.....
Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 18, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
~~Inquest, au-~~
.....find that said deceased came to ~~h~~ death
~~topsy~~ or inquiry.)
on the day stated above.
The CAUSE OF DEATH* was as follows:
Valvular disease of the Heart
(Duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) Dont Know Any
(Duration) yrs. mos. ds.
(Signed) H. K. Gross M. D.
(Coroner.)
8-19, 1920 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cem
DATE OF BURIAL, Aug 21, 1920

20-UNDERTAKER Harry W. Ebbs
ADDRESS 1944 W. North Ave

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20 45842

HEALTH DEPARTMENT—CITY OF BALTIMORE

20 45842

CERTIFICATE OF DEATH.

35

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hosp ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Bailey

(a) RESIDENCE. NO. St Henry Maternal Infirmary ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7/12 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 6-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ollie Bailey

11 BIRTHPLACE OF FATHER (city or town) ? Del
(State or country)

12 MAIDEN NAME OF MOTHER Ora McDonell

13 BIRTHPLACE OF MOTHER (city or town) ? Del
(State or country)

14 Informant Hospital H H
(Address)

15 Filed AUG 19 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1920

17 I HEREBY CERTIFY, That I attended deceased from June 30 1920, to Aug 7 1920, that I last saw h... alive on Aug 17 1920, and that death occurred, on the date stated above, at 1-30 P. m.

The CAUSE OF DEATH* was as follows:

Disseminated Tuberculosis (Lungs, intestines, glands)

(duration) 2 mos.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy. Tb bacilli in sputum

(Signed) Harold L. Stevens, M. D.

8/18 1920 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dalecarroll Md.

20 UNDERTAKER Joseph B. Cook

DATE OF BURIAL Aug 19 1920

ADDRESS 1003 Baltimore Street.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.45843

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45843

91 ✓

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Boyd Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada L. Hodge

(a) RESIDENCE. No. 3540 Frederick Road ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James D. Hodge

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) do.

12 MAIDEN NAME OF MOTHER do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) do.

14 Informant (Address) Boyd Inn Hosp. Bolton, Md.

15 Filed Robert P. Harrison, Registrar

AUG 19 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19, 1920

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1920 to Aug. 18, 1920 that I last saw h[illegible] alive on Aug. 18 1920 and that death occurred, on the date stated above, at 3:10 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? No Phys. Exam.

What test confirmed diagnosis?

(Signed) N. Frederick, M. D.

8/19/20 (Address) Boyd Inn Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug. 21 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Bond St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.458 44 HEALTH DEPARTMENT—CITY OF BALTIMORE D.458 44

CERTIFICATE OF DEATH. 154

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 728 Wyndhurst Ave ST.: 27 WARD)

2-FULL NAME Martha Jane Clark

(a) RESIDENCE. No. 728 Wyndhurst ST., . WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? 88 yrs. 3 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of John S. Clark

6 DATE OF BIRTH (month, day, and year) May 14, 1832

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
88	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joshua B. Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wil. Del.

12 MAIDEN NAME OF MOTHER Annie E. Comegy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Island Md.

14 Informant J. A. Canoles

(Address) 728 Wyndhurst Ave.

15 Filed ..... 19.. Robert P. Harrison, Registrar

Burial Permit Clerk.

THIS IS very Important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920 to Aug 18, 1920.

that I last saw h alive on Aug 17, 1920.

and that death occurred, on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows:

Senile Dementia, one

(Approximate) (duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Hypostatic Congestion of Lungs (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? History + Symptoms

(Signed) R B Norman, M. D.

8.19. 1920 (Address) 354 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 20 " 1920
20 UNDERTAKER J. B. Cook	ADDRESS 1003 N. Balto Street

Spec.—8-24-14—M. & T.—2000 Bks.

0.45845 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 0.45845

CERTIFICATE OF DEATH.

REGISTERED NO. C 1145

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 435 E. 20th St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophronia Jane Sterner

(Residence in Baltimore: No. 435 E. Twentieth St.; 65 yrs., 10 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	married

6-DATE OF BIRTH, Oct. (Month) 13th (Day), 1854 (Year)

7-AGE, 65 yrs. 10 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Newmarket, Balto. Co., Md.

PARENTS.

10-NAME OF FATHER, Ephraim Collett.

11-BIRTHPLACE OF FATHER (State or Country), Newmarket, Balto. Co., Md.

12-MAIDEN NAME OF MOTHER Ann Rosheet.

13-BIRTHPLACE OF MOTHER (State or Country), Newmarket, Balto. Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman J. Sterner,

(Address) 4 E. Virginia Av, City.

15-

Filed....., 191.... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 17th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 23, 1920, to Aug. 17 1920, that I saw her alive on Aug 17 1920, and that death occurred, on the date stated above. at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

(Gall - stones)

(Duration) 1/2 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Hepatic Abscess

(Duration) 4 yrs. mos. 5 ds.

(Signed) Hugh Forsythe M. D.

Aug. 17, 1920. (Address) 424 E North Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Aug. 20, 1920

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Bond Street

D. 45846 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 45846

CERTIFICATE OF DEATH.

1-PLACE OF DEATH (1514 Division St) REGISTERED No. C 176

CITY OF BALTIMORE (No. Union Protestant Infirmary ST.) 14 WARD)

(If death occurred in a hospital or institution, give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Howard Yingling

(Residence in Baltimore: No. (1514 Division St) Union Protestant Infirmary St.; yrs. mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, January (Month) 3 (Day), 1888 (Year)

7-AGE, 32 yrs. 7 mon. 16 dy.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Josephus Yingling

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Sipsky

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Brilhart

(Address) Hampstead, Md.

15- Filed AUG 19 1920, 191.... Robert P Harrison, Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 19 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull as the result of being kicked on the head by his own horse

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Encephalitis

(Duration) yrs. mos. 5 ds.

(Signed) J. A. D. Hennessy M. D. (Coroner.)

August 19, 1920 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). 4

At place of death ....yrs. ....mos. 7 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence Westminster, Md.

19-PLACE OF BURIAL OR REMOVAL, Hampstead Md. DATE OF BURIAL, Aug 21 1920

20-UNDERTAKER Wm Fickes Sons ADDRESS North & Pa

Important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

10.45847 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.45847

CERTIFICATE OF DEATH. 104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 105 Bloomberg ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jos. J. Barnes.

(a) RESIDENCE NO. 105 Bloomberg ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 8 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

If married, widowed, or divorced, HUSBAND of (or) WIFE of Schofield

6 DATE OF BIRTH (month, day, and year) Dec 22-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None - Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Emma Lyddy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Inga Barnes (Address) 105 Bloomberg St

15 Filed AUG 19 1920 19 Robert I. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 17 1920, to Aug 18 1920.

that I last saw h[illegible] alive on Aug 18 1920.

and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Faulty Feeding

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. McClelland M. D.

Aug 19. 1920 (Address) 1299 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

UNDERTAKER

DATE OF BURIAL Aug 20 1920

ADDRESS

TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

045848 HEALTH DEPARTMENT—CITY OF BALTIMORE 045848

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1524 S. Hoffe St. ST.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME James John Younger

(Residence in Baltimore: No. Homberg ave Balto. St.; ..... yrs., mos. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, July (Month) 9 (Day), 1920 (Year)

7-AGE, ...yrs. 1 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Single
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Ora Younger

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Catherine Langrehr

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ora Younger

(Address) Homberg Ave

15- Filed AUG 20 1920, 191.... ROBERT J. KRAUTER Registrar.

Special Fund Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 19 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 17 1920, to Aug 18 1920, that I saw her alive on Aug 18 1920, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Exhaustion

.....

.....

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Diarrhea

Exhaustion (Duration) ....yrs. ....mos. 6 ds.

(Signed) J. Wade M. D.

Aug 19, 1920 (Address) 1163 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Trinity Cemetery	Aug 22, 1920
20-UNDERTAKER	**ADDRESS**
J. Sauder & Son	120 Mad St.

pec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045849 1045849

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 S. East Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mathilda Muller

(a) RESIDENCE. NO. 314 S. East Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Muller

6 DATE OF BIRTH (month, day, and year): Jan 21-1861

7 AGE: Years 59 Months 6 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Albert Sommer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): Herman Minde 314 S. East ave

15 Filed AUG 20 1920 ROBERT E. KRANTZ Registrar

THIS IS VERY IMPORTANT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 19th 1920

17 I HEREBY CERTIFY, That I attended deceased from July 8th, 1920, to Aug 19th, 1920, that I last saw h[illegible] alive on Aug 19th, 1920, and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease
aortic Insufficiency
(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): apoplexy
(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Edw. M. Livingood, M. D.

8/20, 1920 (Address) 5 N. Washington st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

DATE OF BURIAL: Aug 22 1920

20 UNDERTAKER: H. Sander Sons

ADDRESS: 1710 Pred

Spec.—6-9-19—H. P. Co.—1000 Bks.

1945850 HEALTH DEPARTMENT—CITY OF BALTIMORE 1945850

CERTIFICATE OF DEATH. 152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Vincent Infant Asylum ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Dee Paul Rich

(a) RESIDENCE. No. St. Vincent Infant Asylum ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Singles

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 16, 1920

7 AGE	Years	Months	Days	If LESS than 1 day 5 hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Raymond Davis

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Rich

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant S. W. Matthews
(Address) St Vincent Infant Asylum.

15 Filed AUG 20 1920 ROBERT I. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1920, to Aug 17, 1920, that I last saw h alive on Aug 16, 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

5 hours

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Observed

(Signed) Elias Edwards M. D.

(Address) 1504 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Aug 21 1920
20 UNDERTAKER	ADDRESS
M Fahey & Son	1527 W Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45851 HEALTH DEPARTMENT—CITY OF BALTIMORE D45851

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St. Vincents Infant Asylum WARD)

2-FULL NAME. Thaddeus Karaluk

(a) RESIDENCE. No. 1401 Division ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 24, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Karaluk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Cechonski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant C. W. Matthews

(Address) St. Vincent Infant asylum

15 Filed AUG 20 1920 ROBERT F. [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1920

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1920, to Aug 16, 1920.

that I last saw him alive on Aug 16, 1920,

and that death occurred, on the date stated above, at 4 0 m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Heat Prostration

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas A Claudius M. D.

Aug 17, 1920 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Aug 20 1920
20 UNDERTAKER	ADDRESS
W Hachey & Son	1210 N Fork.

Wm H Tarun.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045852

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045852

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 326 S Pulaski ST.; 20 WARD)

2-FULL NAME Wm H. Town

(a) RESIDENCE. NO. 326 S Pulaski ST., 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. 7 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12, 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER W. H. Town

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Amelia Smaltzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wilhemina F. Town (Address) 326 S. Pulaski St.

15 Filed AUG 20 1920 ROBERT E. LEAKER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1920

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1920, to July 19, 1920, that I last saw h alive on July 19, 1920, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(duration) yrs. mos. 3 days

CONTRIBUTORY (Secondary) Acute Gastro Enteric Infection (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptom

(Signed) Howard Kelly M. D.

19 (Address) 2027 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 20 1920
20 UNDERTAKER	ADDRESS
Geo L. Schwab Bro	2011 E Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

2045853.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2045853

63

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 Browne ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Henry Korber.

(Residence in Baltimore: No. 511 Browne St.; 54 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	White	Single

6-DATE OF BIRTH, Oct (Month) 15 (Day), 1865 (Year)

7-AGE 6 yrs. 10 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): Night

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles F. Korber

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Kerste

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Annie B. Wright

(Address) 511 Browne

15- Filed AUG 20 1920, 191... ROBERT B. LEAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 19 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28 1920, to Aug 19 1920, that I saw h[illegible] alive on Aug 18. 1920, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Transverse Myelitis

(Duration) yrs. 2 mos. 21 ds.

CONTRIBUTORY (Secondary) Cerebro Cerebral

(Duration) yrs. mos. ds.

(Signed) Wm. H. Timmes M. D.

Aug 20, 1920 (Address) 700 Harlem Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Aug 21, 1920

20-UNDERTAKER Joshua Sepp — ADDRESS 1600 W North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

045854 HEALTH DEPARTMENT—CITY OF BALTIMORE 045854

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1433 Webb St.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Fuchs

(a) RESIDENCE. No. 1433 Webb ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 5 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harold J. Fuchs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Catherine D. Brenner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr Harold J. Fuchs (Address) 1433 Webb St

15 Filed AUG 20 1920 ROBERT S. ARNOLD Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1920, to Aug 19, 1920, that I last saw h[illegible] alive on Aug 19, 1920, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) 6½ hrs.

CONTRIBUTORY (Secondary) Edematous

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Chas. A. Claudius M. D.

(Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem'y	Aug 20 1920
20 UNDERTAKER Henry Storck Son	ADDRESS 1301 E Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045855

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045855

CERTIFICATE OF DEATH.

28 V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3406 Fait Ave. St.: 76 Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frieda Cumberland.

(a) RESIDENCE. No. 3406 Fait Ave. St., 76 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 22-1902.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	17	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: American Tobacco

(b) General nature of industry, business, or establishment in which employed (or employer): Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore city. Md.

PARENTS

10 NAME OF FATHER: John H. Cumberland.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Margaret Kellner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): John Cumberland. 3406 Fait Ave.

15 Filed AUG 20 1920 ... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 9 1920

17 I HEREBY CERTIFY, That I attended deceased from June 2 1920, to Aug 9 1920, that I last saw h[e] alive on Aug 8 1920, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Pthisis Pulmonalis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no Sputum

What test confirmed diagnosis?

(Signed) M. J. McAvoy, M. D.

8/9 1920 (Address) 839 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Aug. 23 1920
20 UNDERTAKER: Lilly & Geiler.	ADDRESS: 403 S. Mo[illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045856

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045856

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 S. East Ave. ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Joseph Mitchell jr.

(a) RESIDENCE. NO. 708 S. East Ave ST., 26 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single.

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 3-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER Geo J. Mitchell Sr

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret E. Lachoff

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant (Address) Geo J. Mitchell Sr. 708 S. East Ave.

15 Filed AUG 20 1920 ROBERT J. [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1920, to Aug 18, 1920.

That I last saw h in alive on Aug 18, 1920.

and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo D Schmeltz, M. D.

19 (Address) 2815 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem.	Aug. 20 1920
20 UNDERTAKER Lilly & Zeiler.	ADDRESS 1103 E. Mt St.

Spec.—8-24-14—M. & T.—2000 Bks.

1045857 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045857

CERTIFICATE OF DEATH. 1042

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 Harrison Sq. St.; 20 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie K Mally

(Residence in Baltimore: No. 306 Harrison Square St.; yrs. 3 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, April 25, 1920 (Month) (Day) (Year)

7-AGE, yrs. 3 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Charles R. Mally

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Minerva Clements

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. R. Mally

(Address) 831 E. Lombard St

15- AUG 20 1920 Filed....., 191.....

HERBERT R. LEWTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 19, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 17 1920, to Aug 19 1920, that I saw her alive on Aug 18 1920, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

Intoxication

..... (Duration) yrs. mos. 1 ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Howard W Jones M. D.

Aug 20, 191... (Address) Dundalk

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cem	Aug 20, 191...
20-UNDERTAKER Joseph B. Cook	ADDRESS 1043 N Gilmor St

1045858 HEALTH DEPARTMENT—CITY OF BALTIMORE. 1045858

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1338 Pennsylvania Ave ST.) 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Hicks

(Residence in Baltimore: No. 1229 Pennsylvania Ave St.; 41 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, August (Month) 4 (Day), 1879 (Year)

7-AGE, 41 yrs. mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Robt. M. Hicks

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Sadie Flood

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Hicks

(Address) 1338 Penna. Ave

15- AUG 20 1920 Filed ....., 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acc. Drowning

(Duration) yrs. mos. ds.

(Signed) J. S. T. Hennessy M. D. (Coroner.)

Aug 20, 1920 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	Aug 20, 1920
20-UNDERTAKER	ADDRESS
Edw. Ruzgold	1463 N. Carey St

Important. See instructions on the back of this blank.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0.45859 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.45859

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3506 Eastern Ave. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Schaaf Sr

(a) RESIDENCE. No. 3506 Eastern Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. — mos. — ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Johannah Schaaf

6 DATE OF BIRTH (month, day, and year) Sept 10-49

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Schaaf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Wm H. Schaaf 3506 Eastern Av

15 Filed AUG 20 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 19 20, to Aug 18, 1920.

That I last saw h im alive on Aug 18, 1920.

and that death occurred, on the date stated above, at 2:50 P. m.

The CAUSE OF DEATH* was as follows:

Chron. Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No. Specimen taken Urinary T.

What test confirmed diagnosis?

(Signed) Frank A. Gra[illegible] M. D.

19 (Address) 3244 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Aug 21 1920
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.45860 20.45860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1045

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. WARD) 6

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabelle Wilkinson

(a) RESIDENCE. No 113 N. Belnord Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Sam'l. Wilkinson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Kath. Ellinghouse

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Hospital Record J. H. H.
(Address)

15 Filed AUG 20 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 17, 1920 to Aug 20, 1920, that I last saw h.r alive on Aug 20, 1920, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? Patient's home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug 21 1920
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

D.45861

HEALTH DEPARTMENT--CITY OF BALTIMORE

D.45861

CERTIFICATE OF DEATH

40

1 PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 355 Rosebank ave ST. 27 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Catherine F. Hemminghausen

(Residence in Baltimore: No. 355 Rosebank ave. St.: 40 yrs. 4 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Aug 22nd, 1879 (Month) (Day) (Year)

7 AGE: 40 yrs. 11 mos. 27 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9 BIRTHPLACE (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Peter Geibel

11 BIRTHPLACE OF FATHER (State or country): Germy

12 MAIDEN NAME OF MOTHER: Margaret Fissell

13 BIRTHPLACE OF MOTHER (State or country): Germy.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. Kemp Hemminghausen

(Address) 355 Rosebank Ave Town

15 Filed AUG 20 1920, 191

Robert P. Harrison,
REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug. (Month) 19. (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June. 10. 1920. to. Aug 19 1920.
that I saw h.. alive on Aug 19 1920.
and that death occurred, on the date stated above, at 10 A. m.
The CAUSE OF DEATH* was as follows:

General Carcinomata.

(Duration) ..... yrs. 3 mos. ..... ds

Contributory (SECONDARY) Carcinoma of Stomach

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) H. C. Hoen M. D.

Aug. 19, 1920 (Address) 5600 York Rd. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Aug 21 1920.

20 UNDERTAKER: J. Schumacher Son — ADDRESS: 039 Lanvale

state CAUSE OF DEATH in plain terms. Indefinite answers are worthless. Every question is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

H2528
D.45862

HEALTH DEPARTMENT—CITY OF BALTIMORE D.45862

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Gatlis

(a) RESIDENCE. NO. 1029 N Wolfe St. Baltimore WARD.
(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child - [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Gatlis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Della Waddox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) J. Hutt. Bennett

Filed AUG 20 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 19 20

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 19 20, to Aug 14, 19 20,

that I last saw h[illegible] alive on Aug 14, 19 20,

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Dysentery.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) Birth mos. ds.

18 Where was disease contracted if not at place of death? Patients home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) A. W. Stapp, M. D.

, 19 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL Aug 19 1920

20 UNDERTAKER

ADDRESS

Commissioner of Health.

Spec. 6-9-19 H. P. Co. 1000 Blks.

20.45863 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.45863

CERTIFICATE OF DEATH. 41 V

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward L. Grey

(a) RESIDENCE. NO. 812 N Calvert ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Elmira - N.Y.

PARENTS

10 NAME OF FATHER Charles Grey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Susan Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant, Edward L. Grey. (Address) .....

15 Filed AUG 20 1920 19 Registrar Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1920

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1920, to Aug. 17, 1920, that I last saw h.. alive on August 17, 1920, and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Rectum

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia

Cachexia (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? not as yet

What test confirmed diagnosis?

(Signed) F. A. Holden, M. D.

19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	AUG 29 1920
20 UNDERTAKER	ADDRESS
Commissioner Health,	

THIS IS VERY IMPORTANT

Spec.—6-9-19—H. P. Co.—1000 Bks.

45864

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45864

CERTIFICATE OF DEATH.

1-PLACE OF DEATH So. Balto. Gen. Hospital

CITY OF BALTIMORE: (NO. ..... ST.: 24 WARD)

REGISTERED NO. 152

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Shiroky

(a) RESIDENCE. NO. Earleigh, Md ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 17. 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0 0 0

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John James Shiroky

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Agnes Josephine Shiroky

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Austria.

14 Informant John James Shiroky (Address) Earleigh Md

15 Filed AUG 20 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1920. to Aug 19, 1920.

that I last saw him alive on Aug 19, 1920

and that death occurred, on the date stated above, at 11.45P m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) J. O. Conte, Jr. M. D.

, 19 (Address) 1213 Light St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 20 1920
20 UNDERTAKER	ADDRESS
Frank Brach & Son	1905 Aisland ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

10.45865 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 10.45865

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 N. Luzerne ave ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Linwood Crosswell

(a) RESIDENCE. NO. 1310 N Luzerne Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) December 30. 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm W Crosswell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Anna Larkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Wm W. Crosswell

(Address) 1310 N. Luzerne ave

15 Filed AUG 20 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1920, to Aug. 19, 1920

that I last saw him alive on Aug 19, 1920

and that death occurred, on the date stated above, at 11.15 A m.

The CAUSE OF DEATH* was as follows:

Leo Colitis.

(duration) 0 yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos J. Stevens, M. D.

8 20 1920 (Address) 2866 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st Evangelical Luth cemetery	Aug 20th 1920
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

Spec.—8-24-14—M. & T.—2000 Bks.

045866

HEALTH DEPARTMENT—CITY OF BALTIMORE

045866

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C 792

CITY OF BALTIMORE: (No. 423 Homeland Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth J. Hetrick

(Residence in Baltimore: No. 423 Homeland Ave St.; Tipp yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Sept. (Month) 5 (Day) 1863 (Year)

7-AGE, 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Patrick Cavanaugh

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Not Known.

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Hetrick

(Address) 423 Homeland ave

15-

Filed ....., 191.....

Registrar.

Robert P. Harrison,

AUG 20 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 18 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 16 1920, to Aug 18 1920, that I saw her alive on Aug 18 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

General Dropsy superinduced by Valvular Heart Disease

Bright's Disease of Long Standing

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. H. Donovan M. D.

Aug. 19, 1920 (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary Loraus — DATE OF BURIAL, Aug 21, 1920

20-UNDERTAKER, E. A. Wedefeld Jr — ADDRESS Fremont Ave

20.45867

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.45867

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E Boogle

(a) RESIDENCE. NO. 93a Park St Jacksonville Fla. WARD. N. C.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 03 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12-1838

7 AGE 82 Years 3 Months 8 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bn Carolina

PARENTS

10 NAME OF FATHER Geo. W. Boogle

11 BIRTHPLACE OF FATHER (city or town) (State or country) S Carolina

12 MAIDEN NAME OF MOTHER Isabelle Ellison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S Carolina

14 Informant Hospital Record
(Address) J. H. H.

15 Filed Aug 20 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1920

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1920 to Aug 20, 1920, that I last saw h[illegible] alive on Aug 20, 1920, and that death occurred, on the date stated above, at 9.15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate
Metastases to spine.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of prostate

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ga

Did an operation precede death? Yes. Date of May 26

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Howard L. Catt, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hayesville N. C.	Aug 20 1920
20 UNDERTAKER	ADDRESS
J. E. Mitchell	220 W Fayette St

D.45868

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45868

CERTIFICATE OF DEATH.

169

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Off foot of Haubert Street ST.) 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob W. Heselbach. 17 -- 4 -- 28.

(Residence in Baltimore: No. 626 S. Kenwood Ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, March 21st 1903., 1
(Month) (Day) (Year)

7-AGE, 17 yrs. 4 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Deckhand on tug
(b) General nature of industry, business, or establishment in which employed (or employer): Maryland. 0

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER, George B. Heselbach.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Amelia Kratz.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George B. Heselbach. (father)

(Address) 626 S. Kenwood Ave.

15- Robert P. Harrison,

Filed ....., 191..... Registrar.

AUG 20 1920 Special Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 18th 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Accidental fall from tug.
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Aug. 20th 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Carmel	Aug. 22., 1920
20-UNDERTAKER Peter Nicolaus	ADDRESS 2046 Eastern Av.

Cause of death may be important. See instructions on back of certificate.

Feckocheck

D.45869 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45869

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1400 Druid Hill Ave St.; 14th WARD) REGISTERED No. C 1202

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Feckocheck

(Residence in Baltimore: No. 1400 Druid Hill Ave St.; 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female | 4-COLOR OR RACE: white | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): married

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1 ..... (Year)

7-AGE: about 67? yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: Michael Fran

11-BIRTHPLACE OF FATHER (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Johanna Dudy

13-BIRTHPLACE OF MOTHER (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William A. Feckocheck

(Address) 1400 Druid Hill Ave

15- Filed AUG 20 1920, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 20, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heath Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

..... (Duration) 3 yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

August 20 1920 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Aug. 23rd 1920

20-UNDERTAKER: Chas. E. Evans & Son — ADDRESS: 118 W. Mt. Royal Ave.

important. See instructions on back of certificate.

Robert P. Harrison, Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45870

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45870

64V

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 632 N. Madeira ST.: 7 WARD)

2-FULL NAME George W. Edwards

(a) RESIDENCE. NO. 632 N. Madeira ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed~~ or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) July 26 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50		23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Samuel. Edwards

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Richards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Samuel Edwards (Address) 1771 Mullikin St

15 Filed AUG 20 1920 E. Hart P. Harrington Registrar
Burial Permit Clerk.

TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18 1920

17 I HEREBY CERTIFY, That I attended deceased from July 2 1920, to August 18 1920, that I last saw him alive on August 18 1920, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy & Brights Disease

Complications Dr. Kennard

(duration) yrs. 6 mos. 2 ds.

CONTRIBUTORY (Secondary) Brights Disease

(duration) yrs. 6 mos. 2 da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. W. Kennard M. D.

8-19 1920 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	aug 22 1920

20 UNDERTAKER ADDRESS

Milton. Davis 413 N Eden St

Spec.—6-9-19—H. P. Co.—1000 Bks.

Edward W. Gorman

D. 45871

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45871

CERTIFICATE OF DEATH.

79

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital WARD)

2-FULL NAME Mrs. E. H. Gorman (Edward)

(a) RESIDENCE. No. 201 Augusta Avenue WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Charlotte J. Gorman

6 DATE OF BIRTH (month, day, and year) May 19-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	70 yrs	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Builder

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City Md.

PARENTS

10 NAME OF FATHER Wm Gorman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER E. Knipe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Wm. Gorman (Address) 201 Augusta Ave.

15 Filed AUG 20 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1920, to Aug 19, 1920 that I last saw h[illegible] alive on Aug 19, 1920 and that death occurred, on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis & myocardial Insuff.
Chr. Nefritis & Chr. Uremia.

(duration) 10+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema.

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin & Laboratory tests & Urine

(Signed) W. C. Caldwell, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Aug. 21 1920
20 UNDERTAKER	ADDRESS
Wm. E. Black	927 N. Broadway

THIS IS very important

...c.—6-9-19—H. P. Co.—1000 Blks.

0.45872 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 45872

CERTIFICATE OF DEATH.

+ 64

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francisco de Cardona

(a) RESIDENCE. No. Agnadilla PortoRico ST., WARD Agnadilla Porto Rico
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 1 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE: Years 42 Months 11 Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer do

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Agnadilla Porto Rico

PARENTS

10 NAME OF FATHER M. de Cardona

11 BIRTHPLACE OF FATHER (city or town) (State or country): Agnadilla Porto Rico

12 MAIDEN NAME OF MOTHER Eladia Sundoz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Agnadilla Porto Rico

14 Informant: Fr Cardona
(Address): University Hospital

15 Filed AUG 20 1920 Robert P. Harrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1920, to Aug 20, 1920, that I last saw him alive on Aug 20, 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

4 hours, (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Cerebral Hypertension

Chronic Diffuse Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) W. G. Geyer, M. D.

8/20, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Agnadilla Porto Rico

DATE OF BURIAL: Aug 22 19

20 UNDERTAKER: Harry M. Lehr Co

ADDRESS: 163 N. Eutaw

Spec.—8-24-14—M. & T.—2000 Bks.

0.45873 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.45873

CERTIFICATE OF DEATH.

1-PLACE OF DEATH The Howard A. Kelly Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... St.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marjorie Theresa Grunnell.

(Residence in Baltimore: No. The Howard A. Kelly Hospital St.; ....yrs., ...mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, April (Month) 22 (Day), 1904 (Year)

7-AGE, 16 yrs. 3 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Albert Grunnell

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Sallie Nolan

13-BIRTHPLACE OF MOTHER (State or Country), W. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Grunnell

(Address) Hagerstown Md

15-AUG 20 1920 Robert P. Harrison,
Filed....., 191.....
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 20 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 29 1920, to Aug. 20 1920, that I saw her alive on August 20 1920, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Acute Myeloid Leukemia

(Duration) ✓ yrs. ✓ mos. 26 ds.

CONTRIBUTORY (Secondary) Pleural effusion

(Duration) ✓ yrs. ✓ mos. 14 ds.

(Signed) Arthur C. Primrose M. D.

Aug. 20, 1920 (Address) 1418 Eutaw Place
The Howard A. Kelly Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ✓ yrs. ✓ mos. 23 ds. In the State 16 yrs. 4 mos. 1 ds.

Where was disease contracted, if not at place of death? Atlantic City.

Former or usual residence Hagerstown, Md.

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Aug 23, 1920

20-UNDERTAKER Chas. S. Evans & Son ADDRESS 1810 Mont Royal Ave

Spec.—8-24-14—M. & T.—2000 Blks.

245874 HEALTH DEPARTMENT—CITY OF BALTIMORE 245874

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 Aiken ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Judith Ann Stahl

(Residence in Baltimore: No. 1816 Aiken St.; 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Wid

6-DATE OF BIRTH, Nov 17, 1856 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
64 yrs. 9 mos. 1 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, John P Stahl

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Judith A. Durrer

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Chas. Myers

(Address) 1816 Aiken st.

15- Robert P. Harrison,

Filed....., 191..... Registrar.

AUG 20 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 18, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from APR 1 1920, to AUG 18 1920, that I saw her alive on AUG 18 1920, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilated heart

(Duration) 1 yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis and Myocarditis X

(Duration) 1 yrs. 6 mos. X ds.

(Signed) O. H. Durrer M. D.

AUG 20 1920 (Address) 928 E North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Aug. 21, 1920

20-UNDERTAKER George J. Ruth — ADDRESS 735 Harford Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45875 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45875

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1314 E Lafayette av. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Elizabeth Pfeiffer.

(a) RESIDENCE. NO. 1314 E Lafayette Av. ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 4 1889

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
31	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt Md

PARENTS

10 NAME OF FATHER: John M. Pfeiffer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: C Ksoll

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt Md.

14 Informant: John Pfeiffer (Address) 1314 E Lafayette ave

15 Filed Aug 20, 1920 Robert P. Haslup, Registrar

Burial Permit Clerk.

THIS IS NOT A BURIAL PERMIT.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1920, to Aug 18, 1920, that I last saw h alive on Aug 18, 1920, and that death occurred, on the date stated above, at 9 C, m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro enteritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John W. Sanderson M. D.

Aug 21, 1920. (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 21 20
20 UNDERTAKER	ADDRESS
George L Ruth	1733 Harford

D.45876 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45876

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 13 Dash Hospital St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen M Fowler

(Residence in Baltimore: No. 3200 Greenmount St.; yrs. 10 mos. 1 ds. 16)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, white | 5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July 3rd (Month) (Day), 1910 (Year)

7-AGE, 10 yrs. 1 mos. 16 ds. | If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Frank P Fowler

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Margaret Alice Griffin

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gertrude Fink

(Address) 923 N. Caroline St

15-

AUG 20 1920 Robert P. Harrison, Registrar.

Clerk.

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 19 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism bi cycle

Coma (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm Smiley M. D. (Coroner)

Aug 19, 1920 (Address) 4 E Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Aug 21, 1920
20-UNDERTAKER	ADDRESS
Wm C Miller	2334 Jefferson St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45877 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45877

CERTIFICATE OF DEATH. Mary E. Lutz.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital St.: 10 WARD)

REGISTERED NO. 1202

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Lutz

(a) RESIDENCE. NO. 1035 Somerset ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 15 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
~~50~~	68	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph Lutz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) , ,

14 Informant Mr. Jas. Lutz. (Address) 2008 E Lanvale St

15 Filed AUG 21 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/20/ 19 20

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 19 20, to Aug. 20, 19 20, that I last saw h.. alive on Aug 20, 19 20, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Intest Disturb

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) F. C. Marino, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug 23 19
20 UNDERTAKER	ADDRESS
Henry Hosek Son	1301 E Eager St

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 45878

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45878

CERTIFICATE OF DEATH.

30

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Tolton

(a) RESIDENCE. No. 16 S. Spring St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Feb 18 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Archie Tolton

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Ora Dyer

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Hospital Record
(Address) J. H. H.

15 Filed Robert P. Harrison, Registrar
6 21 1920
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19th 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 12, 1920, to Aug 19, 1920, that I last saw h.... alive on Aug 19, 1920, and that death occurred, on the date stated above, at 1:40 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Patients home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Ernest Sapp, M. D.

, 19 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Aug 22 1920
20 UNDERTAKER	ADDRESS
Chas. H. Johnson	446 N. Carolina

Spec.—8-24-14—M. & T.—2000 Bks.

D.45879 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45879

CERTIFICATE OF DEATH.

REGISTERED No. C 79 V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. N.E. Cor Greenmount & 11th Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Preston Fallon

(Residence in Baltimore: No. N. E. Cor. Greenmount & Montebello St.; Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Nov. (Month) 5 (Day), 1887 (Year)

7-AGE, 32 yrs. 9 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Smith Bros

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jos. P. Fallon

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Ella E. Keenan

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Robt. Fallon

(Address) 2500 E. North Ave

15- AUG 21 1920 Robert P. Harrison, Registrar.
Filed ....., 191.... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 20 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 18th 1920, to Aug. 20th 1920, that I saw him alive on Aug. 19th, 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency with
Acute Interstitial Nephritis
Latter about (Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Asthma
(Duration) ....yrs. ....mos. 3 ....ds.

(Signed) Mary F. Vogelsang M. D.
Aug 20, 1920. (Address) 1028 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral	Aug 23., 1920
20-UNDERTAKER	ADDRESS
H. C. Wedefeld	914 Greenmount Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

0.45880 0.45880

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital REGISTERED No. C.....

CITY OF BALTIMORE: (No. ..... ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ambrose A. Runaldue

(Residence in Baltimore: No. 1404 Madison Ave St.; ....yrs. ....mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, September 16, 1853 (Month) (Day) (Year)

7-AGE, 66 yrs. 11 mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) ..... "

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. John A Runaldue

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Mary Smith

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Runaldue

(Address) 1404 Madison Ave

15-

Filed ..... 191.. P. Harrison, Registrar.

Deputy Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 21, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 17 1920, to Aug 21 1920, that I saw him alive on Aug 20 1920, and that death occurred, on the date stated above, at 3.45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestine.

(Duration) 1 yrs. 15 mos. ..... ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) J. H. Harrison M. D.

Aug 21, 1920. (Address) 11 W. 7th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 9 ds. In the State ..... yrs. ..... mos. 9 ds.

Where was disease contracted, if not at place of death? Virginia

Former or usual residence Colonial ave. Norfolk Va.

19-PLACE OF BURIAL OR REMOVAL. Norfolk Va — DATE OF BURIAL, Aug 24, 191..

20-UNDERTAKER William Cook — ADDRESS 502 E. Main Ave

AUG 21 1920

Spec.—6-9-19—H. P. Co.—1000 Bks.

20,45881 HEALTH DEPARTMENT—CITY OF BALTIMORE 20,45881

CERTIFICATE OF DEATH. + 1032

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. May E mmett

(a) RESIDENCE. No. Halethorpe Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 10 mos. 25 ds. How long in U. S., if of foreign birth? 43 yrs. 10 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Housewife

6 DATE OF BIRTH (month, day, and year) Sept 26 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43 yrs	10	25	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William H Slade

11 BIRTHPLACE OF FATHER (city or town) Bald Co Md (State or country) " " "

12 MAIDEN NAME OF MOTHER Susan Kesler

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md (State or country)

14 Informant Mrs. Chas Emmett

(Address) Halethorpe Md.

15 Filed AUG 21 1920 19 Robert P. Harrison, Registrar

[Burial Permit Clerk]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1920

17

I HEREBY CERTIFY, That I attended deceased from May 20, 1920, to Aug 20, 1920 that I last saw alive on Aug 20, 1920, and that death occurred, on the date stated above, at 2:00 p. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

Pylorus obstruction

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/19/20

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) H. McElwain, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 23 1920
20 UNDERTAKER	ADDRESS
Jos B Cook	1003 N Balto

D. 45882 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 45882

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 928 N. Vincent St.: 16 WARD)

2-FULL NAME Mary Perry

(Residence in Baltimore: No. 928 N. Vincent St.

REGISTERED No. C 645

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

45 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Widow

6-DATE OF BIRTH, Unknown, 1859
(Month) (Day) (Year)

7-AGE, 69 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): 041

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Murray

(Address) 928 Vincent St

15- Robert F. Harrison,
AUG 21 1920 Filed ....., 191.....
Burial Permit Clerk. Registrar.

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 19, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 2 yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

August 20 1920 (Address) 1802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, W^m Auburn — DATE OF BURIAL, Aug 22 1920

20-UNDERTAKER Sam'l H. Chase & Son — ADDRESS 140a Mosher

Spec.—8-24-14—M. & T.—2000 Bks.

0.45883 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.45883

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 559 Walnut al ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Harris

(Residence in Baltimore: No. 559 Walnut al. St. Life yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, ... Unknown (Month) (Day), 1889 (Year)

7-AGE, 31 yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): (37)

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Cornelius Bracco

11-BIRTHPLACE OF FATHER (State or Country), U.S.A. Co. Md

12-MAIDEN NAME OF MOTHER Lina Moore

13-BIRTHPLACE OF MOTHER (State or Country), Balto - Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Bracco

(Address) 5 N. Wilson St

15- Robert P. Garrett,

Filed ... 1920 ... 191.. Pursuit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 19th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 17 1920, to Aug 19th 1920 that I saw h.er alive on Aug 17th 1920 and that death occurred, on the date stated above, at 4 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary and Laryngeal Tuberculosis

(Duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Influenza as 1918

(Duration) yrs. mos. 10 ds.

(Signed) Chas. Keller M. D.

Aug 14, 1920 (Address) 2227 Wm

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Aug 21 20

20-UNDERTAKER David D Hendley ADDRESS 518 N Bond St

Spec.—5-19-13—M. & T.—500 Bks.

0.45884

HEALTH DEPARTMENT—CITY OF BALTIMORE

D/45884

CERTIFICATE OF DEATH.

1262

1-PLACE OF DEATH 1213 Myrtle Ave

REGISTERED NO. C

CITY OF BALTIMORE: (No. ..... ST.: 17 ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H. Shaw

(Residence in Baltimore: No. 1213 Myrtle Ave St.; 42 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	married

6-DATE OF BIRTH. March 18, 1867
(Month) (Day) (Year)

7-AGE. 61 yrs. 5 mos. One ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Mercantile

9-BIRTHPLACE. (State or Country). Clark County Pennsylvania

PARENTS.

10-NAME OF FATHER. David Shaw

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Co Md.

12-MAIDEN NAME OF MOTHER Juliana Ray

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs James H Shaw

(Address) 1213 Myrtle Ave

15- Robert F. Harrison,

Filed AUG 21 1920, 191.... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 19, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 12th, 1920, to Aug 19th 1920, that I saw h.. alive on Aug 16th 1920, and that death occurred, on the date stated above, at 2-40 Pm.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) ....yrs....mos. 1/2 ds.

CONTRIBUTORY (Secondary) Prostatic Hypertrophy

(Duration) ?? yrs. ....mos. ....ds.

(Signed) Samuel Hyatt M. D.

Aug 19, 1920 (Address) 1715 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Aug 22, 1920

20-UNDERTAKER John W Henderson — ADDRESS 1502 E monument

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45885 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45885

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 905 N. Guy ST. 10 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E. Morgan

(a) RESIDENCE. No. 905 N. Guy ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (~~or, WIFE~~) of: Sallie Morgan

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 53 | Months 4 | Days 20 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer): 09
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Md.

PARENTS
10 NAME OF FATHER: James Morgan
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.
12 MAIDEN NAME OF MOTHER: Marion Bunyman
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co.

14 Informant: Eddie Little
(Address) 905 N. Guy St.

15 Filed ... 19.. ? Harris, Registrar

G 21 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8. 20 1920

17 I HEREBY CERTIFY, That I attended deceased from August 16 1920 to Aug 20 1920
that I last saw h[illegible] alive on Aug 20 1920
and that death occurred, on the date stated above, at 1/2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Cerebral Oedema
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Harold A. Mettee M. D.
19 20 (Address) 1031 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Darlington Md.
DATE OF BURIAL: Aug. 23 1920
20 UNDERTAKER: Hebert S Bailey
ADDRESS: Darlington Md

TION is very important.

D.45886 HEALTH DEPARTMENT--CITY OF BALTIMORE D.45886

CERTIFICATE OF DEATH

1139

1 PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE (No. 1006 E. Biddle St. 10 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Augusta H. Aston

(Residence in Baltimore: No. 1006 E. Biddle St.: Unknown. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married.

6 DATE OF BIRTH: October (Month) 21 (Day), 1859 (Year)

7 AGE: 60 yrs. 9 mos. 28 ds. | If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Maryland.

PARENTS

10 NAME OF FATHER: John Bertermann

11 BIRTHPLACE OF FATHER (State or country): unknown.

12 MAIDEN NAME OF MOTHER: Henriette Lange

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John P Aston
(Address) 1006 E Biddle St

15. Filed AUG 21 1920 Robert P Harrison, REGISTRAR
Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: August (Month) 20 (Day), 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 8, 1920, to August 20 1920, that I saw her alive on August 19, 1920, and that death occurred, on the date stated above, at 12:59 m.
The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver,

(Duration) 2 yrs. 7 mos. 1 ds

Contributory (SECONDARY) Exhaustion

(Duration) 1 yrs. 1 mos. 12 ds.

(Signed) Frederick L. Hunner M. D.
Aug 20, 1920. (Address) 112 E. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Pk | DATE OF BURIAL: Aug 23 1920

20 UNDERTAKER: Eaud B Hake | ADDRESS: 115 E Ves[illegible]

state CAUSE OF DEATH in plain terms. ... is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45887 HEALTH DEPARTMENT—CITY OF BALTIMORE D45887

CERTIFICATE OF DEATH

291

1-PLACE OF DEATH Bay View Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blair Fritch

(a) RESIDENCE. No. Unknown ST., WARD. Kansas

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant Bay View Hospital (Address) Balto. Md.

15 Filed AUG 21 1920 Robert P. Harrison, Registrar

Burial Permit Clerk,

THIS is very important. See that it is correctly filled out.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1919, to Aug 18, 1920, that I last saw h— alive on Aug. 17, 1920, and that death occurred, on the date stated above, at 4.35 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No Phys. Con.

What test confirmed diagnosis?

(Signed) W. H. Hedgecock, M. D.

8/21 1920 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincents Cem	Aug 21 1920

20 UNDERTAKER Chas F. Evans & Son ADDRESS 118 W. Mt. Royal Ave

Spec.—8-24-14—M. & T.—2000 Blks.

D.45888 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45888

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 29 E. Church ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin Henry Gross.

(Residence in Baltimore: No. 29 E. Church St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Col.	Single

6-DATE OF BIRTH. July 13th, 1920
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
....yrs. 1 mos. 8 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Wm. H. Gross

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Elizabeth Smith

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Wm Gross

(Address)..... 29 E. Church St.

15-

Filed..... 191.....

Robert P. Harrison,
Registrar.

UG 21 1920
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 21st, 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 18 1920, to Aug 21st 1920, that I saw him alive on Aug 20 1920, and that death occurred, on the date stated above, at 1.30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis
Intoxication.

(Duration)....yrs....mos. 10 ds.

CONTRIBUTORY.....
(Secondary)

(Duration)....yrs....mos....ds.

(Signed) D. H. Harrell M. D.

8/21, 1920. (Address) 140 W. Hull St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodlawn	Aug. 22, 1920
20-UNDERTAKER	ADDRESS
J. L. Browne & Son	108 Monty

D.45889 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45889

CERTIFICATE OF DEATH.

64 ✓

REGISTERED No. C

1 PLACE OF DEATH
CITY OF BALTIMORE (No. 1815 Jefferson St. 6 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Henry Greenwald
(Residence in Baltimore: No. 1813 Jefferson St.; yrs. 58 mos. 5 ds. 9)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Mar 10th, 1862
(Month) (Day) (Year)

7-AGE, 58 yrs. 5 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Meter
(b) General nature of industry, business, or establishment in which employed (or employer) Gas Works

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Geo. Greenwald

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fannie Greenwald
(Address)

15-
Filed AUG 21 1920 Robert F. Harrison, Registrar.
Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 19, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Apoplexy.
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) H K Justice M. D.
Aug 20 1920 (Coroner) (Address) 1816 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Co
DATE OF BURIAL, Aug 23 1920

20-UNDERTAKER Philip Henrig
ADDRESS 2016 Orleans

IMPORTANT. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45890 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45890

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 E. Cross ST. 24 WARD) 1702

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine J. Belz

(a) RESIDENCE. NO. 121 E Cross ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. — mos. — ds. How long in U. S., if of foreign birth? 71 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Belz

6 DATE OF BIRTH (month, day, and year) Feb. 13, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Hesse Cassell
(State or country) Germany

PARENTS

10 NAME OF FATHER Henry Heine

11 BIRTHPLACE OF FATHER (city or town) Hesse Cassell
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Koeirim

13 BIRTHPLACE OF MOTHER (city or town) Hesse Cassell
(State or country) Germany

14 Informant Charles Henry Belz
(Address) 901 Appleton St

15 Filed ..... 19 Robert P. Harrison, Registrar

AUG 21 1920 Burial Permit Clerk.

TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1920, to Aug 20, 1920, that I last saw h er alive on Aug 19, 1920, and that death occurred, on the date stated above, at 1:50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Albuminuria - Nephritis

(Signed) Walter K. Kenny, M. D.

. 19 (Address) 3517 Fairview Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	AUG 23 1920
20 UNDERTAKER	ADDRESS
JOHN F. DENNY	715 LIGHT ST.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45891 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45891

CERTIFICATE OF DEATH. 1042

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 Hanover ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Langley

(a) RESIDENCE. NO. 528 Hanover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm. Langley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Myrtle Dyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm. Langley
(Address) 528 Hanover St.

15 Filed Aug 21 1920 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1920, to Aug 20, 1920, that I last saw her alive on Aug 20, 1920, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Septicemia,

(duration) yrs. mos. 1 3 ds.

CONTRIBUTORY (Secondary) Erysipelas

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Z. Ashby Hall, M. D.

, 19 (Address) 355 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. Ann. Rd.

DATE OF BURIAL Aug 24 1920

20 UNDERTAKER F. A. Frazier & Son

ADDRESS 703 Hanover St.

TION is very important. See instructions.

G 21 1924 [illegible] Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Blks.

10.45892 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.45892

CERTIFICATE OF DEATH. 1320

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 W. Stockholm ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas O Brien

(a) RESIDENCE. No. 712 W. Stockholm ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of the late Mary O Brien.

6 DATE OF BIRTH (month, day, and year) April 6 - 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) " "
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country)

14 Informant Jacob Donaldson
(Address) 722 W Stockholm St

15 Filed ... 19... Robert P. Harrison, Registrar

AUG 21 1920 Burial Permit Clerk.

TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1920

17 I HEREBY CERTIFY, That I attended deceased from July 22 1920, to Aug 18, 1920, that I last saw h— alive on Aug 18, 1920, and that death occurred, on the date stated above, at 7.45 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Chronic

(duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic

(duration) 4 yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Gundelfinger, M. D.

8/20. 1920 (Address) 517 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional instance.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted]ATE OF BURIAL

Cedar Hill Aug 23 1920

20 UNDERTAKER Wm Cook ADDRESS 5025 North Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

0.45893 — 6420.45893

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 56 annapolis ave St.; Hillen Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Elizabeth Hill

(Residence in Baltimore: No. 56 annapolis ave Hollins St.; 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, Colr

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widowed

6-DATE OF BIRTH, unknown (Month) any (Day) 8, (Year) 1849

7-AGE, 69 yrs. mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Wom
(b) General nature of industry, business, or establishment in which employed (or employer): NPD.

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Donald Robert.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Elza Cosa

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Hill (Son)

(Address) 1137 Carrollton Ave

15- AUG 21 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 19 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 25 1920, to Aug 18 1920, that I saw h er alive on Aug 18, 1920, and that death occurred, on the date stated above, at 12.25 a m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis 20 yrs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma & Exhaustion

(Duration) yrs. mos. ds.

(Signed) W B Hall M. D.

Aug 19, 1920 (Address) Hospital

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Aug 21, 1920

20-UNDERTAKER Edw. Quggold — ADDRESS 1463 W Lanvale St

Spec.—6-9-19—H. P. Co.—1000 Bks.

0.45894 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.45894

CERTIFICATE OF DEATH.

92

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 751 Raborg ST.; 4 WARD)

2-FULL NAME Frank Brown

(a) RESIDENCE. NO. 751 Raborg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Julia E. Brown

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Screwman
(b) General nature of industry, business, or establishment in which employed (or employer) 074
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Julia E. Brown (Address) 707 Raborg St

15 Filed Aug 21 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

THIS SECTION IS VERY Important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1920, to Aug 18, 1920, that I last saw him alive on Aug 18, 1920, and that death occurred, on the date stated above, at 5:40 P. m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) — yrs. — mos. 18 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) — yrs. — mos. 18 ds.

18 Where was disease contracted if not at place of death? 767 Raborg Street

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) Thos H. Fowler, M. D.

Aug 21 1920 (Address) 712 S Sharp Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Aug 22 1920
20 UNDERTAKER John H. Toadvine	ADDRESS 142 Ostend St

Spec.—6-9-19—H. P. Co.—1000 Bks.

10.45895 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.45895

CERTIFICATE OF DEATH.

1201

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 S. Eutaw ST.: 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Green

(a) RESIDENCE. NO. 816 S. Eutaw ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Elizabeth Green (Address) 816 S. Eutaw St

15 Filed Aug 21 1920 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1920

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1920, to Aug 20, 1920, that I last saw her alive on Aug 20, 1920, and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(duration) yrs. 3 mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 3 mos. 2 ds.

18 Where was disease contracted if not at place of death? 816 S. Eutaw St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Arteriosclerosis

(Signed) C. W. Groves M. D.

(Address) 712 S. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Aug 23 1920
20 UNDERTAKER John H. Trader	ADDRESS 142 Ostend St

TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D45896 HEALTH DEPARTMENT—CITY OF BALTIMORE D45896

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 9 N. Exeter St ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME DORA WINNER

(a) RESIDENCE. NO. 9 N Exeter St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Winner

6 DATE OF BIRTH (month, day, and year) Unknown 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1411 Eastaton St

15 Date AUG 22 1920 ROBERT E LEAVELL Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20th 1920

17 I HEREBY CERTIFY, That I attended deceased from ——— 1918, to Aug 20th 1920, that I last saw her alive on " " 1920, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob L. Winner, M. D.

8-21 1920 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Hebrew Rem	8/22 1920
20 UNDERTAKER Jack Lewis	ADDRESS 1411 Eastaton

TION is very important. See instructions on

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

045897 — 7a 045897

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Esplan- Place extended — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel E. Reinhard

(Residence in Baltimore: No. Esplanade Apts. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, April 5 (Month) (Day), 1855 (Year)

7-AGE, 65 yrs. 4 mos. 15 ds. — If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clothing Manufac
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Emanuel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Henriella Max

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Reinhard

(Address) Esplanade Apts

15- AUG 22 1920 ROBERT E KRAETZER

Filed....., 191..... Registrar.

Burial Permit .....

Important. See that every question is answered.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 20 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 6 1920, to Aug 20 1920, that I saw h— alive on Aug 19 1920, and that death occurred, on the date stated above, at 1.35 P m.

The CAUSE OF DEATH* was as follows:

Streptococcus Endocarditis (Viridans)

..... (Duration) ..... yrs. 10 mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Michael A Abrams M. D.

Aug 21, 1920. (Address) 2360 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Hebrew Cem	Aug 22 1920
20-UNDERTAKER	**ADDRESS**
J. Ahrens & Co	1611 Mad

ae

D45898 HEALTH DEPARTMENT—CITY OF BALTIMORE D45898

CERTIFICATE OF DEATH.

REGISTERED No. C 167

1-PLACE OF DEATH
CITY OF BALTIMORE (No. St Joseph Hospital WARD)

2-FULL NAME Harold Fleischmann.

(Residence in Baltimore: No. 616 S. East ave

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word) Single

6-DATE OF BIRTH, Aug (Month) 25 (Day), 1916 (Year)

7-AGE. 3 yrs. 11 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore city.

PARENTS.

10-NAME OF FATHER. John Fleischmann

11-BIRTHPLACE OF FATHER (State or Country). Balto. city.

12-MAIDEN NAME OF MOTHER Eva. Bebow

13-BIRTHPLACE OF MOTHER (State or Country). Balto. city.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Fleischmann

(Address) 616 S. East Ave

15-
Filed AUG 22 1920 ROBERT E. KRAUTER Burial Permit Clerk
191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug (Month) 20 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I ~~took charge of~~ the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereof and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Burns. Mother spilled Carbolic acid on baby from broken bottle

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) (Duration) ...yrs. ...mos. ...ds.

(Signed) J. Knox Insley M. D.
(Coroner)
191... (Address) 4 E. East St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Sacred Heart
DATE OF BURIAL, Aug 22 1920

20-UNDERTAKER Lilly & Zile
ADDRESS 403 S Wolfe St

CAUSE OF DEATH must be stated. Every question must be answered if possible. Certificate must be filled out before burial. Please write plainly and make important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045899 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045899

CERTIFICATE OF DEATH.

152

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 N. Eight St ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irving F. E. Badenburg Jr

(a) RESIDENCE. NO. 108 N. Eight St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 7 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Irving F. Badenburg Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary E. Westervelt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Irving F. Badenburg

(Address) 108 N. Eight St

15 Filed AUG 22 1920 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1920, to Aug 20, 1920, that I last saw h[illegible] alive on Aug 20 1920, and that death occurred, on the date stated above, at 8 45 A. m.

The CAUSE OF DEATH* was as follows:

Streptococcus Meningitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Infection of Tibia

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. E. Hamer, M. D.

, 19 (Address) 1321 Bat Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Matthews Cem.	Aug 22 1920
20 UNDERTAKER H. Lander & Sons	ADDRESS 1710 Fleet

TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

1045900

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150 1045900

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 4005 Falls Road ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elsie May Dammyer

(Residence in Baltimore: No. 4005 Falls rd St.; ..... yrs., 9 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, June (Month) 27 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
....yrs. 1 mos. 29 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....—
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, William Dammyer

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Bertha Fowble

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Dammyer

(Address) 4005 Falls Rd

15-

Filed AUG 22 1926, 191.... ROBERT I KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 21st (Month) (Day), 1920 (Year)

17-I HEREBY CERTIFY, That I attended deceased from August 1920, to Aug 21st 1920, that I saw her alive on Aug 21 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute dilitation of heart

(Duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary) Congenital Cardiac insufficiency

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Vernon F Kelly M. D.

Aug 21, 1920 (Address) 3105 Falls Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Wiselburg Balto Co	Aug 23 1920
20-UNDERTAKER	ADDRESS
Ede Roy Stiffler	1255 North ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45901 HEALTH DEPARTMENT—CITY OF BALTIMORE D45901

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 155 N. Exeter St ST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hirsh Krashes

(a) RESIDENCE. NO. 155 N Exeter St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Krashes

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

065

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J Lewis 1411 E Balt St

15 Filed AUG 22 1920 Serial Permit ... Registrar

TION is very important. See instructions on ba...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-21 1920

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1920, to Aug. 20, 1920 that I last saw h m alive on Aug. 20, 1920, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

about 7 ds.

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Myocarditis Several years.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theodore H. Morrison M. D.

, 19 (Address) 1013 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	8/22 1920
20 UNDERTAKER Jack Lewis	ADDRESS 1411 E Balt St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45902 D45902

CERTIFICATE OF DEATH.

REGISTERED No. C 15

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E. Monument St. ST.; 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Waxenman

(Residence in Baltimore: No. ..... St.; ..... yrs. ..... mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Aug. (Month) 19 (Day), 1920 (Year)

7-AGE, ... yrs. ..... mos. 2 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. David Waxenman

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Mary Badenoff

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 941 E. Balt. St.

15- Filed AUG 22 1920, 191... BOBERT I EMANUEL Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 21 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 19 1920, to Aug 21 1920, that I saw her alive on Aug. 21 1920, and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH* was as follows:

Effuse Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Difficult labor

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ernest Ellwood M. D.

Aug. 21, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ..... mos. 1 ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herring Run

DATE OF BURIAL, 8-22, 1920

20-UNDERTAKER Jack Lewis

ADDRESS 941 E. Balt St

Important. See instructions.

D45903. HEALTH DEPARTMENT--CITY OF BALTIMORE D45903.

CERTIFICATE OF DEATH + 104

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1025 Lamont Layman Ave St. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margie Evans

(Residence in Baltimore: No. 1028 Layman Ave St.: 5 mos. 6 yrs. mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Infant

6-DATE OF BIRTH: January 24, 1920 (Month) (Day) (Year)

7-AGE: ..... yrs. 6 mos. 27 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE (State or country): Albany, New York

PARENTS

10-NAME OF FATHER: Rex H Evans

11-BIRTHPLACE OF FATHER (State or country): Boston Mass.

12-MAIDEN NAME OF MOTHER: Louise B Jones

13-BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rex H. Evans

(Address) 1025 Lamont Ave.

15-Filed AUG 22 1920, 19.. ROBERT J. BRAUER, Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: August 21st, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 12th, 1920, to Aug. 21, 1920, that I saw h[illegible] alive on August 20th, 1920, and that death occurred, on the date stated above, at 7 5 A m. The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Woodward M. D.

Aug 21st 1920 (Address) 16 North Front St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death				In the State			

Where was disease contracted, if not at place of death? Former or usual residence? New York.

19-PLACE OF BURIAL OR REMOVAL: Western Cemetery — DATE OF BURIAL: Aug. 23rd 1920

20-UNDERTAKER: M. & Mrs. John H. Teufel — ADDRESS: 801 W Fayette

State CAUSE OF DEATH in plain terms, so that it may be properly coded. Certificate is very important. See instructions on back of certificate.

2033 N Charles St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0045904

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 0045904

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Beidler & Sellman ST.: 17 WARD)

2-FULL NAME Catherine Presley

(a) RESIDENCE. NO. 411 E. 31st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph Presley.

6 DATE OF BIRTH (month, day, and year) Feb. 2 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frederick Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila - Pa.

12 MAIDEN NAME OF MOTHER Margaret Schafer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Christopher Miller
(Address) 575 Franklin Terrace

15 Filed AUG 22 1920 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 16, 1920, to Aug 21, 1920, that I last saw her alive on Aug 21, 1920, and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Uterine Fibroid

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Surgical shock

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? Yes Date of Aug 16, '20

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Geo. W. Dorsett, M. D.

8/21, 1920 (Address) 2020 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fowden Park	Aug 27, 1920

20 UNDERTAKER William Cook ADDRESS 5025 North ave

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045905

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045905

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. 1309 Maryland ST.; 11 WARD)

2-FULL NAME Pauline E. Burkhardt

(a) RESIDENCE. NO. 1309 Maryland ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14-1920

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Leo S. Burkhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Philadelphia

12 MAIDEN NAME OF MOTHER Helen Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Leo S. Burkhardt

(Address) 1309 Maryland St

15 Filed AUG 22 1920 19... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1920, to Aug 20, 1920, that I last saw h[illegible] alive on Aug 20, 1920, and that death occurred, on the date stated above, at 12:15 P m.

The CAUSE OF DEATH* was as follows:

Acute Ileo-Colitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Ruxton P.O.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Ralph L. Voight M. D.

, 19 (Address) 26 E Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Wash Hayden

DATE OF BURIAL Aug 22 1920

20 UNDERTAKER William Cook

ADDRESS 507 E Lombard

TION is very important. See instructions on

Spec.—8-24-14—M. & T.—2000 Bks.

D45906 HEALTH DEPARTMENT—CITY OF BALTIMORE 120 D45906

CERTIFICATE OF DEATH.

1-PLACE OF DEATH:
CITY OF BALTIMORE: (No. 1324 Dellwood ST.; 13th WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca Bowersox

(Residence in Baltimore: No. 1324 Dellwood St.; 47 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	white	Married

6-DATE OF BIRTH, Sept. (Month) 24 (Day), 1860 (Year)

7-AGE, 59 yrs. 10 mos. 26 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Howard Co.

PARENTS.

10-NAME OF FATHER, Ferdinand Stevens

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Mary Redman

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis J. Bowersox

(Address) 1324 Dellwood Ave

15- ROBERT J. KRAUTER

Filed AUG 22 1920 191. Assistant Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 19 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1920, to Aug 19 1920, that I saw her alive on Aug 19 1920, and that death occurred, on the date stated above, at 9:45 a. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ....yrs. 3 mos. 4 ds.

(Signed) O. F. Cornblum M. D.

8-19, 1920 (Address) 307 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Maria (Govans Md.)	Aug. 23, 1920.
20-UNDERTAKER	ADDRESS
Horace Burgess	1363 Hall St.

important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

2045907

HEALTH DEPARTMENT—CITY OF BALTIMORE

2045907

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 N. North Ave ST.: 15 WARD)

2-FULL NAME Wolf Joffe

(a) RESIDENCE. No. 1717 N. North Ave ST.... WARD.....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rosa Joffe

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Left Store

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Joffe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lubenman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lubenman

14 Informant Mrs Joffe 1717 N. North

(Address)

15 Filed AUG 22 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21st 1920

17 I HEREBY CERTIFY, That I attended deceased from June, 1920, to Aug, 1920, that I last saw h.r alive on Aug 20, 1920, and that death occurred, on the date stated above, at 1005 m.

The CAUSE OF DEATH* was as follows:

Myocarditis -

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) angina pectoris

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) I. Frederick Lentz, M. D.

Aug 22, 1920 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balt Hebrew	Aug 22 1920
20 UNDERTAKER	ADDRESS
Harold Sondheim	1020 Druid Park

TION is very important. See instructions on back

Spec.—8-24-14—M. & T.—2000 Bks.

D45908

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45908

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 737-S- Linwood St.; (If) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew. P. McGarrell

(Residence in Baltimore: No. 737- S- Linwood St.; 19 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, 12 (Month) 23 (Day), 1854 (Year)

7-AGE, 65 yrs. 7 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Attorney at Law

9-BIRTHPLACE, (State or Country). Wheeling W Va

PARENTS.

10-NAME OF FATHER, Laurence McGarrell

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ann O'Hanlon

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. P. McGarrell

(Address) 633-S-Fay

15- AUG 22 1920 ROBERT I. TRAUTH

Filed....., 191.... Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 21 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 6/15/20 191..., to 8/21/20 191..., that I saw h[im] alive on 8/21/20 191..., and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 5 yrs. mos. ds.

(Signed) A. P. McGarrell M. D.

8/21/20 191... (Address) 633-S-Fay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Wheeling W. Va.

19-PLACE OF BURIAL OR REMOVAL, Wheeling W. Va — DATE OF BURIAL, Aug. 24, 1920

20-UNDERTAKER Geo. W. Link & Son, — ADDRESS 1111 N. Main

Funeral Directors & Embalmers

Important. See instructions on back of this sheet.

Spec.—8-24-14—M. & T.—2000 Bks.

045909

HEALTH DEPARTMENT—CITY OF BALTIMORE

045909

CERTIFICATE OF DEATH.

1044

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 Mc Henry St. ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabelle Rebecca Hoffman

(Residence in Baltimore: No. 1004 N. Lombard St. St.; yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec 15, 1919
(Month) (Day) (Year)

7-AGE, ...yrs. 8 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Charles R Hoffman

11-BIRTHPLACE OF FATHER (State or Country), Frederick Co Md

12-MAIDEN NAME OF MOTHER Laiue R Ingram

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas R Hoffman

(Address) 1004 N Lombard St

15- AUG 22 1920 Filed....., 191.... ROBERT B LAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 21, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 5 1920, to August 21 1920, that I saw her alive on August 20 1920, and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Edgar C. Travers M. D.

Aug 21, 1920 (Address) 1520 Hollins St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem. DATE OF BURIAL, Aug 23rd, 1920.

20-UNDERTAKER Jno J. Cowan & Son ADDRESS 901 Hollins St

important. See instructions on back of this sheet.

Spec.—5-19-13—M. & T.—500 Blks.

D45910

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45910

CERTIFICATE OF DEATH.

REGISTERED NO. C 42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823 Pulaski St ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie Belt.

(Residence in Baltimore: No. 1823 Pulaski St St.: 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. January 26, 1865. (Month) (Day) (Year)

7-AGE. 55 yrs. 7 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Carroll co Md

PARENTS.

10-NAME OF FATHER. James Reynolds

11-BIRTHPLACE OF FATHER (State or Country). England

12-MAIDEN NAME OF MOTHER Jane B Calloway

13-BIRTHPLACE OF MOTHER (State or Country). England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Chas. A. Silance

(Address) 1823 N Pulaski st.

15. AUG 23 1920 Filed....., 191... ROBERT P. FOUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 21, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 14 1920, to Aug 21 1920, that I saw h-- alive on Aug 21 1920, and that death occurred, on the date stated above, at 9-20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

7

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Abscess of Uterus

(Duration) 1 yrs. mos. ds.

(Signed) W. S. Gump M. D.

Aug 22, 1920. (Address) 622 N. Monroe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Freedom Carroll co.

DATE OF BURIAL. Aug 23., 1920

20-UNDERTAKER Jas. R. Weer

ADDRESS Sykesville Md

important. See instructions on back of

Spec.—8-24-14—M. & T.—2000 Blks.

Jans

D45911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45911

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 112 N Carlton St.; 18 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Victoria Jans

(Residence in Baltimore: No. 112 N. Carlton St.; 3 yrs., 1 mos. 25 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Child

6-DATE OF BIRTH, June (Month) 27 (Day), 1913 (Year)

7-AGE, 3 yrs. 1 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, William T Jans

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary M Denton

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary M Denton

(Address) 112 N. Carlton St.

15- AUG 23 1920 ROBERT J KRAUTER

Filed....., 191.... Registrar.

important. See instructions on back of

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 21 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1920, to Aug 20 1920, that I saw h[illegible] alive on Aug 20 1920, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration)....yrs....mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) H G Hardesty M. D.

8/21, 1920 (Address) 1131 Carlton a

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Lorel Cem	Aug 23, 1920
20-UNDERTAKER Thos F Eyland	ADDRESS 114 N Schroeder St

Bowers.

Spec.—6-9-19—H. P. Co.—1000 Bks.

045912 HEALTH DEPARTMENT—CITY OF BALTIMORE 045912

CERTIFICATE OF DEATH. 425

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 W Fayette ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L Bowers

(a) RESIDENCE. NO. 1411 W. Fayette ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nadow

6 DATE OF BIRTH (month, day, and year): July 20 1862

7 AGE: Years 58 Months 1 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Augustus Wolf

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary P. Muse

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Wolf

(Address) 1411 W. Lombard

15 Filed AUG 23 1920 ROBERT F. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 22 1920

17 I HEREBY CERTIFY, That I attended deceased from aug 8th 1920, to Aug 22 1920, that I last saw h alive on Aug 20 4 1920, and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Inoperable Lung Cancer

Contributory Asthma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Byrd Cleary, M. D.

19 (Address) 1105 N Paca St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Aug 25 1920

20 UNDERTAKER: John Shields — ADDRESS: 1200 W Lombard

TION is very important. See instructions on

Spec.—8-24-14—M. & T.—2000 Bks.

1045913

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045913

CERTIFICATE OF DEATH.

104 1045913

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 3128 O Donnell St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ludovica Lanocha

(Residence in Baltimore: No. 3128 O'Donnell St.; ....yrs., 10 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Oct 4, 1919
(Month) (Day) (Year)

7-AGE, ...yrs. 10 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Lanocha

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Frances Reves

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Lanocha

(Address) 3128 O'Donnell St

15-
Filed AUG 23 1920, 191.... ROBERT P. HEALTH. Registrar.
Burial Permit

important. See instructions on back of Certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 27, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1920, to Oct 21 1920, that I saw h-er alive on Oct 21 1920, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Acute Mes Colitis

5

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) Leo Lankenau M. D.

Aug 27, 1920 (Address) 3225 O'Donnell

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Thomas Lane

DATE OF BURIAL, Aug 24, 1920

20-UNDERTAKER Wm Hall Sons & Co

ADDRESS Eastern ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D45914 D45914 104 D45914

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp. St.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Genovefa Stasukiewicz

(Residence in Baltimore: No. 122 S. Wolfe St.; yrs. 2 mos. 10 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) [illegible]

6-DATE OF BIRTH. May (Month) 31 (Day), 1920 (Year)

7-AGE. 2 yrs. 10 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..."
(b) General nature of industry, business, or establishment in which employed (or employer) ..."

9-BIRTHPLACE. (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Justyn Stasukiewicz

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Jozefa Szczepanek

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Justyn Stasukiewicz

(Address) 122 S Wolfe

15- Filed AUG 23 1920, 191.... ROBERT P. BRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. August 22 (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 22 1920, to August 22 1920, that I saw h[illegible] alive on August 22 1920, and that death occurred, on the date stated above, at 1159 m.

The CAUSE OF DEATH* was as follows:

Acute intestinal indigestion

(Duration) ....yrs. ....mos. 6 ....da.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....da.

(Signed) [illegible] M. D.

....., 1920 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 2 mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 122 S Wolfe St.

Former or usual residence 122 S Wolfe St.

19-PLACE OF BURIAL OR REMOVAL. Holy Rosary — DATE OF BURIAL. Aug 25 1920

20-UNDERTAKER [illegible] — ADDRESS 1608 East

important. See instructions on back of [illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

045915

045915

CERTIFICATE OF DEATH.

20

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 E. Gilling ST.) 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick L. Wolf

(Residence in Baltimore: No. 413 E. Gilling St.; 46 yrs., 11 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, August 24, 1873 (Month) (Day) (Year)

7-AGE 46 yrs. 11 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) Nat. Enamel & Stamp.

9-BIRTHPLACE, (State or Country). Balto. City

PARENTS.

10-NAME OF FATHER. Geo. Wolf

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Eva A. Wolf

(Address) 413 E. Gilling

15- AUG 23 1920 ROBERT B KRAUTER

Filed ..... 191.. Registrar.

important. See instructions on back of certificate

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 21, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 11 1920, to Aug 21 1920, that I saw him alive on Aug. 20 1920, and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Septicaemia due to Infection of left foot

(Duration) ..... yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robt. E. C. Schmidt M. D.

Aug. 21, 1920 (Address) 1318 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL, 8/24, 1920

20-UNDERTAKER J. F. McCully ADDRESS 130 E. Fort

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45916 HEALTH DEPARTMENT—CITY OF BALTIMORE D45916

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 520 Columbia ST.; 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Kolb wife

(a) RESIDENCE. No. 520 Glen Bourie ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Aug 2/20

7 AGE: Years — Months — Days 19 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Steve Kolb.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Tena. Berna[illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Steve Kolb. (Address) 520. Columbia Ave.

15 Filed AUG 23 1920 OBERT I [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 21 1920.

17 I HEREBY CERTIFY, That I attended deceased from aug 20, 19 20, to aug 21, 19 20, that I last saw h[illegible] alive on aug 21, 19..., and that death occurred, on the date stated above, at 1P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) ....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Hans Bozz M. D.

8-7. 1920 (Address) 602 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: aug 23 1920

20 UNDERTAKER: John Gobliunckas — ADDRESS: 425 S. Pac

Spec.—8-24-14—M. & T.—2000 Bks.

Wolleab.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045917 1045917

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital 79 REGISTERED NO. C

CITY OF BALTIMORE: (No. 1914 Division ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Dorothea Wolkrab

(Residence in Baltimore: No. 2226 E. Chase Street St.; 68 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Oct. 19, 1831 (Month) (Day) (Year)

7-AGE, 88 yrs. 10 mos. 3 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Mr. Gruener

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Wolkrab

(Address) 1214 N. Central Ave.

15. AUG 23 1920 Filed ....., 191.... ROBERT P. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 22, 1920 (Month) (Day) (Year) 1920

17- I HEREBY CERTIFY, That I attended deceased from Aug 16 1920, to Aug 22 1920, that I saw h.. alive on Aug 22 1920, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Senile deterioration

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) yrs. mos. 2 1 ds.

(Signed) T. H. Jamieson M. D.

Aug 22, 1920 (Address) U. M. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 7 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 2226 E Chase.

Former or usual residence 2226 E. Chase St.

19-PLACE OF BURIAL OR REMOVAL Cedar Hill | DATE OF BURIAL, Aug 24 1920

20-UNDERTAKER Sirkler & Sirkler | ADDRESS 1739 Eager

important. See instructions on back of certificate

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45918

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45918

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3715 E. Lanvard ST.; 26 WARD)

2-FULL NAME Thomas V. Chase

(a) RESIDENCE. NO. 3715 E. Lanvard ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 3rd 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	—	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Son

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Paul G. Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary D. Fitsch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Paul G. Chase
(Address) 3715 E. Lanvard

15 Filed AUG 23 1920 ROBERT J. BRAUTE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21st 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 10, 1920, to Aug. 21, 1920, that I last saw h[illegible] alive on Aug 21, 1920, and that death occurred, on the date stated above, at 1.50 p. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea + Enteritis

(duration) 1 yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Gastritis

Malnutrition (duration) 1 yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gen. Physician

(Signed) Jas R Titus, M. D.

Aug 22, 1920 (Address) 2485 E 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fitsch Farm Belair Rd	Aug 23 1920
20 UNDERTAKER	ADDRESS
Philip Herwig	2016 Orleans

TION is very important. See instructions on back of certificate.

D45919 HEALTH DEPARTMENT—CITY OF BALTIMORE D45919

CERTIFICATE OF DEATH. 17

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry J. Wurstland

(Residence in Baltimore: No. N. Point Road near Seminole Rd. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white.	Married

6-DATE OF BIRTH, Feb. (Month) 7 (Day) 1875 (Year)

7-AGE, 37 yrs. 6 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Paper Cutter
(b) General nature of industry, business, or establishment in which employed (or employer)..... 059

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Henry Wurstland

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma C. Wurstlein

(Address) N. P. Rd.

15- AUG 23 1920 ROBERT B. BRAUTH

Filed ....., 191..... Registrar.

CAUSE OF DEATH in plain terms. If this is important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 21 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture skull fell 30 feet off platform at mine Coke.

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) J. Kent Smith, M. D. (Coroner.)

8-23-1920 (Address) 4 E. Eden St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	Aug. 24, 1920
20-UNDERTAKER	ADDRESS
Philip J. Herring	2016 Orleans St.

D45920 HEALTH DEPARTMENT—CITY OF BALTIMORE D45920

CERTIFICATE OF DEATH.

169

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Fredrick ave ST.: 20 WARD) Forrest Falls

2-FULL NAME Williams F Murray

(Residence in Baltimore: No. 1929 Mt. Henry St.; yrs., mos. ds.)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, April 14, 1914
(Month) (Day) (Year)

7-AGE, 6 yrs. 4 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Invalid
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Wm F. Murray

11-BIRTHPLACE OF FATHER (State or Country), Washington DC

12-MAIDEN NAME OF MOTHER Effie Morrison

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Effie Murray

(Address) 1929 Mt. Henry St

15- AUG 23 1920 ROBERT P. KRAUTH, Registrar.
Filed....., 191.....

CAUSE OF DEATH to be filled in by Physician only. Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suffocation in water
in Patapsco River
Accident Suddenly
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Fenton M. D.
(Coroner.)
Aug 22 1920 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, Aug. 24, 1920

20-UNDERTAKER Harry H. Ketzke

ADDRESS 1531 W. Lombard St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45921

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45921

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 Harwood Ave ST. 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret M Finneman

(a) RESIDENCE. NO. 924 Harwood Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — —

6 DATE OF BIRTH (month, day, and year) May 7-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER James Finneman

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Nannie Emory

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

11 Informant James Finneman

(Address) 924 Harwood Ave.

12 Filed AUG 23 1920 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 21st 1920

17 I HEREBY CERTIFY, That I attended deceased from August 10th 1920, to August 21st 1920, that I last saw he alive on August 21st 1920, and that death occurred, on the date stated above, at 11½ P m.

The CAUSE OF DEATH* was as follows:

Diarrhea & enteritis

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? His Home

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Stewart M. D.

9/22 1920 Address) 1701 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 8/23 1920

20 UNDERTAKER: Chas F. Evans & Son — ADDRESS: 1182 N. Mt. Ave.

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

045922

HEALTH DEPARTMENT—CITY OF BALTIMORE

X104

045922

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 S. Ann ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen Balko

(Residence in Baltimore: No. 604 S. Ann St.; yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, January (Month) 9 (Day), 1920 (Year)

7-AGE, yrs. 7 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Pass Christian Miss

PARENTS.

10-NAME OF FATHER, Sirko Balko

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Anne Dicky

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sirko Balko

(Address) 604 S. Ann St.

15- AUG 23 1920 ROBERT F. KRAUTER

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 16 1920, to August 18 1920, that I saw him alive on August 18 1920, and that death occurred, on the date stated above, at 7 30 p.m.

The CAUSE OF DEATH* was as follows:

.....
.....
Diarrhoea
..... (Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Indigestion
..... (Duration) yrs. mos. 8 ds.

(Signed) [illegible] M. D.

August 23 1920 (Address) 722 S. Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Pass Christian Miss

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Stanislaus.	Aug 23, 1920
20-UNDERTAKER	**ADDRESS**
W. F. Sadowski.	705 S. Ann

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D45923

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45923

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 N. Milton ave ST.; 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Schaaf Jr

(Residence in Baltimore: No. 916 N Milton Ave St.; yrs. 8 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Sn

6-DATE OF BIRTH, Dec 29 (Month) (Day), 1911. (Year)

7-AGE, ...yrs. 8 mos. 8 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, John Schaaf

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Minnie Wagner

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Schaaf

(Address) 916 N Milton Ave

15- AUG 23 19[illegible] ROBERT P. KRAUTER Registrar.

Filed....., 191.....

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 21 (Day), 1911 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/20 1911, to 8/20 1911, that I saw h[illegible] alive on 8/20 1911, and that death occurred, on the date stated above, at 4 15 a.m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis & Ileo colitis

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Acute furuncle

(Duration) ....yrs. ....mos. 1 ds.

(Signed) J. H. D. Bullock M. D.

8/20, 1911. (Address) 1623 E. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Carmel Cem

DATE OF BURIAL. Aug 23, 1911.

20-UNDERTAKER Jas C. Miller

ADDRESS 2337 Jefferson

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45924

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 45924

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mrs. D. K. Carters Sanitorium (St.:) Gorsuch (Ward)

2-FULL NAME Maria F Gibson

(a) RESIDENCE. No. Albion Hotel St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1836. ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84 ?	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York ?

PARENTS

10 NAME OF FATHER Geo. Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER M.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Richard Pleasants
(Address) 1011 Munsey Bldg

15 Filed AUG 23 1920 ROBERT F. KRAETER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21 1920.

17 I HEREBY CERTIFY, That I attended deceased from Aug 15th, 1920, to Aug 21st, 1920, that I last saw her alive on Aug 20th, 1920, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Arterio - Sclerosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Course.

(Signed) Jos. Chatard, M. D.

Aug 21st, 1920 (Address) 40 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old St Pauls Cemetery — DATE OF BURIAL Aug 23rd 1920

20 UNDERTAKER Henry W Jenkins Sons Co — ADDRESS McCulloh & Orchard

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045925 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045925

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1738 N. Calhoun ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florian Krumholtz

(a) RESIDENCE. NO. 1738 N. Calhoun ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Krumholtz

6 DATE OF BIRTH (month, day, and year): Sept 18-826

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	94	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoe Maker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry Krumholtz

[illegible] N. Calhoun

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 22. 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1920, to Aug 22, 1920, that I last saw h. m alive on Aug 18, 1920, and that death occurred, on the date stated above, at 1045 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. —mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Edw Jacobs M. D.

, 19 (Address) 1353 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W E S Term	Aug 26 1920
20 UNDERTAKER: William Cook	ADDRESS: Fort & York

TION is very important. See instructions on back of

Spec.—6-2-19—H. P. Co.—1000 Bks.

D45926 HEALTH DEPARTMENT—CITY OF BALTIMORE D45926

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 Hilltop Road ST.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Lohmeyer

(a) RESIDENCE. No. 202 Hilltop Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Lohmeyer

6 DATE OF BIRTH (month, day, and year): Dec 25 1842

7 AGE — Years: 77 — Months: 7 — Days: 27 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Deceased

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wm. C. Lohmeyer
(Address) 202 Hilltop Rd.

15 AUG 23 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 21 1920

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1920, to Aug 21, 1920
that I last saw him alive on Aug 21, 1920
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis and Myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas Lohmeyer, M. D.

19 20 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rockhurst All Saints Cemetery — DATE OF BURIAL: Aug 24 1920

20 UNDERTAKER: Wm Cook — ADDRESS: Ft & Mt

TION is very important. See instructions on

Wm McCann.

D45927 HEALTH DEPARTMENT—CITY OF BALTIMORE 1722 D45927

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. No 3 Belvedere Court ST.; 26 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm McCann

(Residence in Baltimore: No. 1922 St. 5th Ave

5 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 55 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. Nickels

(Address) 5 W 5th Ave

15-

Filed AUG 23 1920, 191.....

ROBERT B KRAUTER

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 20, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Shooting of Skull

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shot from gun

Alcoholism (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Danl Ryan Coroner D.

Aug 23, 1920 (Address) 100 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Aug 23, 1920
20-UNDERTAKER	ADDRESS
Stephen J Frankowski	1000 W Lanvale St

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D46928

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45928

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2831 Remington Ave ST.) 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen Price

(Residence in Baltimore: No. 2831 Remington Ave St.) 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1860 (Year)

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), A. A. Co Md

PARENTS.

10-NAME OF FATHER, Herman Butler

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Matilda Sorbus

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dan Price

(Address) 1416 E. Madison St

15-
Filed AUG 23 1920 191 ROBERT B LAUTER Registrar.

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 21, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 16 1920, to Aug 21 1920, that I saw her alive on Aug 21 1920, and that death occurred, on the date stated above, at 3P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. Indef mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. Indef mos. ds.

(Signed) L A Pleehart M.D.

Aug 23 1920 (Address) 1132 N 25 St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Lawn — DATE OF BURIAL, Aug 23 1920

20-UNDERTAKER Sam H. Chase & Son — ADDRESS 1600 N Fulton

Spec.—8-24-14—M. & T.—2000 Bks.

D45929

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D45929

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 535 S. Bentalou ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresa M Stricker

(Residence in Baltimore: No. 535 S Bentalou St.: ..... yrs., 10 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Oct (Month) 14 (Day), 1917 (Year)

7-AGE, ... yrs. 10 mos. 8 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Edward P Stricker

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Delia Teague

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Stricker

(Address) 5358. Bentalou St

15-

Filed AUG 23 1920, 191.....

SOBERY & KRAUTER

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 22 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1920, to Aug 22 1920, that I saw h-r alive on Aug 22 1920, and that death occurred, on the date stated above, at 8 — m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Bertram C Hetzel M. D.

Aug 22, 1920. (Address) 2151 Linkwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL New Cathedral — DATE OF BURIAL, Aug 24, 1920

20-UNDERTAKER Geo Lohmeyer & Bro — ADDRESS 2101 Eutaw Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.45930 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45930

CERTIFICATE OF DEATH. 1052

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2412 St. Paul St. ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret J. Garrett

(a) RESIDENCE. No. 2412 St. Paul ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George W. Garrett

6 DATE OF BIRTH (month, day, and year) Dec 13 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER John P. Distadt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Margaret Garrett
(Address) 2412 St. Paul St.

15 Filed AUG 23 1920 Robert F. Harris, M.
Registrar
Burial Permit Clerk.

CAUSE OF DEATH. The following items must be accurately and fully filled in. See instructions on back of certificates. DIAGNOSIS MUST BE GIVEN IN THIS CASE. INFORMATION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1920

17 I HEREBY CERTIFY, That I attended deceased from June 24th, 1920, to Aug 22, 1920.
that I last saw her alive on Aug 22, 1920.
and that death occurred, on the date stated above, at 1 P m.
The CAUSE OF DEATH* was as follows:

Infirmities of age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diarrhea none

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. F. Gabriel, M. D.

, 19 (Address) 2413 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Aug. 24 1920

20 UNDERTAKER Wm C. Black ADDRESS 427 N. Broadway

20.45931 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.45931

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore

CITY OF BALTIMORE (No. General Hospital. ST.: 24 WARD) 75-001

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hyman D. Schenker.

(Residence in Baltimore: No. 52 West St. Annapolis Md. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH,

Do not know. (Month), (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
22 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoemaker.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country),

Russia.

PARENTS.

10-NAME OF FATHER, Isaac S. Schenker.

11-BIRTHPLACE OF FATHER (State or Country), Russia.

12-MAIDEN NAME OF MOTHER Ella Pickstein.

13-BIRTHPLACE OF MOTHER (State or Country), Russia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Schenker. (brother).

(Address) 16 Market Place Annapolis

15- Robert P. Harrison,

Filed ....., 191.....

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 22nd, 1920. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Injuries.
Caught between a fence rail and an Automobile.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. M. Bernhard M. D.
(Coroner)

Aug. 23rd., 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Annapolis Blvd. near Cedar Hill Cemetery

Former or usual residence 52 West St. Annapolis Md

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herring Run — DATE OF BURIAL, 8/24, 1920

20-UNDERTAKER Jack Lewis — ADDRESS 1411 Back St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

AUG 23 1920

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 45932 HEALTH DEPARTMENT—CITY OF BALTIMORE D 45932

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1207 Durst Alley ST.: 24th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Shugars.

(a) RESIDENCE. No. 1207 Durst Alley ST. 24th WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 3, 1920

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
			20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md.

PARENTS

10 NAME OF FATHER James Shugars

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Alice Travers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant James Shugars (Address) 1207 Durst Alley.

Filed AUG 23 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 23, 1920

17

I HEREBY CERTIFY, That I attended deceased from August 16, 1920, to August 23, 1920, that I last saw h er alive on August 20, 1920, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth
and
Inanition

(duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? 7 Month Baby - Underweight.

(Signed) Henry F. Buettner, M. D.

, 19 (Address) 1049 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross C.	Aug 23 1920
20 UNDERTAKER	ADDRESS
John J Fahey Son	1318 Light St

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Rks.

D.45933

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45933

T 120

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth E. Stabler.

(a) RESIDENCE. NO. Md. General Hospital ST., WARD. Sparrows Point - Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 6 mos. 0 ds. How long in U. S., If of foreign birth? 62 yrs. 10 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of (none)

6 DATE OF BIRTH (month, day, and year) Oct - 9 - 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Freelands - Balto. Co. Md

PARENTS

10 NAME OF FATHER Danl E. Stabler

11 BIRTHPLACE OF FATHER (city or town) Freelands (State or country) Balto. Co. Md

12 MAIDEN NAME OF MOTHER Catherine E. Wilhelm

13 BIRTHPLACE OF MOTHER (city or town) Freelands (State or country) Balto Co. Md

14 Informant Mr. Wm. G. Stabler (Brother)
(Address) 703-E-E-St Sparrows Point

AUG 23 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 22 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to August 22, 1920, that I last saw h.r alive on August 22, 1920, and that death occurred, on the date stated above, at 600 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Chronic Diffuse Arthritis.
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Decompensation
(duration) yrs. 14 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) E. Wilbur Stewart, M. D.

8/22. 1920 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Freelands - Balto. Co. Md. DATE OF BURIAL: Aug 25 1920

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS: 108 W. NORTH AVE.

N. B.—Answers to questions should be carefully supplied. AGE should be correctly stated, as upon this information depends the value of many statistical tables. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45934 HEALTH DEPARTMENT—CITY OF BALTIMORE D45934

CERTIFICATE OF DEATH. 1159

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2509 Elsinor Av ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Austen Gibson

(a) RESIDENCE. No. 2509 Elsinor Av ST., 15 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? 82 yrs. 4 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Hollingsworth Gibson

6 DATE OF BIRTH (month, day, and year) April-10-1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	82	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles R. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hagerstown Maryland

12 MAIDEN NAME OF MOTHER Georgianna Millemon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mrs Young A. Wilson Jr. (daughter) (Address) 2509 Elsinor ave.

15 Filed ..... 19 Robert F. Harrison, Registrar

AUG 25 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1920, to Aug 22, 1920, that I last saw her alive on Aug 21, 1920, and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

Senile

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2509 Elsinor Av

Did an operation precede death? no Date of ——

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) A L Schimpeler M. D.

Aug 22 1920 (Address) 2806 Eastern Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL All Saints Cemetery Reisterstown Md — DATE OF BURIAL Aug. 24/1920

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH: In plain words, give the disease causing death, or in deaths from violent causes, state the means and nature of injury. DO NOT USE TERMS OF MODE OF DYING, such as heart failure, asthenia, etc. BUT GIVE THE DISEASE CAUSING THESE CONDITIONS. If fever, state number of days ill. If from accident, state when occurred. If maternal state, state whether pregnant or puerperal. If a woman, state whether single, married, widowed or divorced. This information is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 45935 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 45935

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1336 W. Lafayette ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~William~~ Richard Morse Chenoweth

(a) RESIDENCE. No. 1336 W. Lafayette ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 8 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leordelia Chenoweth

6 DATE OF BIRTH (month, day, and year) Nov. 14-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of Industry, business, or establishment In which employed (or employer)

(c) Name of employer Sun Office

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm. H. Chenoweth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ida M. Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant J. H. Lovekamp (Address) Jessup Md

15 Filed AUG 23 1920 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21 1920

17 I HEREBY CERTIFY, That I attended deceased from July 26th, 1920, to Aug. 21st, 1920, that I last saw h in alive on Aug 20th, 1920, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yr. 3 mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Chas C. Habbeston, M. D.

, 19 (Address) 37 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Aug 24 1920
20 UNDERTAKER Wm J Frazier & Sons	ADDRESS Norfolk Va

mation should be given in answering these questions, so that it may be properly
CAUSE OF DEATH in plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45936 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45936

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bredlow-Bellman Sanit. 1082

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2724 N Charles St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James B. Mosby

(Residence in Baltimore: No. 2100 Ogden Ave St.; 54 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May (Month) 9 (Day), 1849 (Year)

7-AGE.	If LESS than 1 day,
71 yrs. 3 mos. 14 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, John R. Miller

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Martha R. Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Grace Merritt

(Address) 2107 Bolton St.

15-

Filed AUG 23 1920, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1920, to Aug 23 1920, that I saw him alive on Aug 22 1920, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows: Myocarditis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) 0 yrs. mos. 2 ds.

(Signed) Jno L. Ellis M. D.

8/23, 1920 (Address) 2017 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Aug 25 1920
20-UNDERTAKER	ADDRESS
Wm J Pickerton	N Y Pa

CROSS OUT words not important. See instructions on back of certificate.

D.45937 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45937

642

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 3727 Eastern Ave St.: 1 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew J. Adams

(Residence in Baltimore: No. 3727 Eastern Ave St.: yrs. 66 mos. 8 ds. 12

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF DATE OF BIRTH: Dec 1, 1863 (Month) (Day) (Year)

7-AGE: 66 yrs. 8 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machanist
(b) General nature of industry, business, or establishment in which employed (or employer): 31

9-BIRTHPLACE, (State or Country): City

PARENTS.

10-NAME OF FATHER: Benj. Adams

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Susan Smith

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louisa Adams

(Address) 3727 Eastern Ave

15-

Filed ....., 191.....

Registrar.

Robert P. Harrison,

Burial Permit Clerk.

AUG 22 1920

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Aug 21, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) A. J. Connolly M. D. (Coroner)

Aug 23, 1920 (Address) 1500 Eastern Ave

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Aug 25, 1920

20-UNDERTAKER: H. E. Lichtenberg — ADDRESS: North Ave

*CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45938

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45938

104

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1632 Westwood Avenue St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Van Dam Ker Jr
(Residence in Baltimore: No. 1632 Westwood Avenue St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Mal	White	Sngl

6-DATE OF BIRTH: February 15th (Month) (Day), 1920 (Year)

7-AGE, ... yrs. 6 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Int any
(b) General nature of industry, business, or establishment in which employed (or employer): Dod

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Geo W. Van Dam Ker.

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER Carrie Conran

13-BIRTHPLACE OF MOTHER (State or Country). New York City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo W. Van Dam Ker
(Address) 1632 Westwood Avenue

15- Robert P. Harrison,
Filed ..... 191..... Registrar.

CAUSE OF DEATH. This line must be filled in. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 21st (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 18th 1920, to August 21st 1920, that I saw h im alive on August 21st 1920, and that death occurred, on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis

(Duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Syphilis) (Duration) ... yrs. ... mos. ... ds.

(Signed) William J. Sherman M. D.
8/21, 1920 (Address) 1201 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Aug. 24th 1920
20-UNDERTAKER W J Tuckner & Son	ADDRESS North Ave

Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

D.45939

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45939

CERTIFICATE OF DEATH.

REGISTERED NO. C 1215

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 N Exeter st ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Caristi

(Residence in Baltimore: No. 412 N Exeter st St.; ....yrs. ....mos. 17 ds.)

N. B.—Every item of information should be carefully classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	white	

6-DATE OF BIRTH. 8-6-1920
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Calogero Caristi

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Pietrina Anastasia

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Paterino Caristi

(Address) 412 N. Exeter

15- Filed AUG 23 1920, 191.... Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8-22-1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8-20-1920, to 8-22-1920, that I saw h[illegible] alive on 8-22-1920, and that death occurred, on the date stated above, at 9.41 m.

The CAUSE OF DEATH* was as follows:

General debility

(7 months term baby)

(Duration) ....yrs. ....mos. 17 ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Charles Lula M. D.

....., 191... (Address) 210 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Vincents Cem	Aug 24, 1920
20-UNDERTAKER	ADDRESS
Geo Schillinger & Son	Monument Sq & Aisquith

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45940

CERTIFICATE OF DEATH.

1920 D45940

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1122 May ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James L. Jones

(a) RESIDENCE No. 1122 May ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Jones

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Mary Jones

(Address) 1122 May St

15 Filed AUG 24 1920 ROBERT E LEATHERBURY Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21 1920

I HEREBY CERTIFY, That I attended deceased from 6/22, 1920, to 8/21, 1920, that I last saw him alive on 8/20, 1920, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows: Chronic interstitial nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Fair

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? No Date of

Was there an autopsy? No.

What tests confirmed diagnosis? Clinical

(Signed) Jno. B. Robinson, M. D.

(Address) 520 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Aug 26 1920

20 UNDERTAKER Mrs Robert or Elliott Carnival

ADDRESS 1720

Be sure that it may be properly classified. Information should be carefully supplied. Read CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45944

CERTIFICATE OF DEATH.

31 D45944

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp. ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Mooney

(a) RESIDENCE. No. 1632 E Madison St ST., WARD. Johns Hopkins Hospital

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, ~~widowed~~, or ~~divorced~~
HUSBAND of ~~(or) WIFE of~~ Wilhelmina Mooney

6 DATE OF BIRTH (month, day, and year) July 4 - 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57	1	18		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Wesley

11 BIRTHPLACE OF FATHER (city or town) (State or country) D. C.

12 MAIDEN NAME OF MOTHER Rachel Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Record (Address) J. H. H.

15 Filed ....., 19.... Registrar

AUG 24 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 21, 1920, to Aug 22, 1920, that I last saw him alive on Aug 22, 1920, and that death occurred, on the date stated above, at 9 15 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction.

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Tuberculosis pulmonalis with cavern formation

(duration) ? yrs. — mos. ? ds.

18 Where was disease contracted if not at place of death? at patients home 1632 E. Madison St.

Did an operation precede death? Yes Date of July 21, '20

Was there an autopsy? Yes

What test confirmed diagnosis? Operation and autopsy

(Signed) Jay McLean, M. D.

(Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cem	Aug 25 20.
20 UNDERTAKER	ADDRESS 1725
Jno R. Talbott & Son	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations must not be used. Any information not obtainable should be reported as "unknown." ATTENTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045942

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 1045942

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 Haw St. ST.: 22 WARD)

2-FULL NAME Charles Conquest

(a) RESIDENCE. No. 637 Haw St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgana Conquest

6 DATE OF BIRTH (month, day, and year) Dec. 15, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Steamship

(c) Name of employer Balto. Chespk. and Atlantic S.S.Co Accomac Co.

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Littlton Coquest

11 BIRTHPLACE OF FATHER (city or town) Accomac Co. (State or country) Va.

12 MAIDEN NAME OF MOTHER Hester Ashby

13 BIRTHPLACE OF MOTHER (city or town) Accomac Co. (State or country) Va.

14 Informant Georgana Conquest (Address) 637 Haw St.

15 Filed AUG 24 1920 ROBERT S. [illegible] Registrar

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly coded on back of certificates. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) ~~Aug 20~~ Aug 21st 1920.

17 I HEREBY CERTIFY, That I attended deceased from August 1st, 1920, to Aug. 21, 1920, that I last saw him alive on August 19th 1920, and that death occurred, on the date stated above, at 12:25 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar) Cardiac Falue (Right heart)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic congestion of lungs (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? at place of death.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	8/24/20
20 UNDERTAKER	ADDRESS
Geo. W. Joachim	142 W Hill St

1045943 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045943

CERTIFICATE OF DEATH.

REGISTERED NO. C 172

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Ridgely near Ostend Sts. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Zachariah Young.(C).

(Residence in Baltimore: No. 1031 Calhoun Stl St.; 50. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Widower.

6-DATE OF BIRTH, Do not know. (Month), 1 (Day), (Year)

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer in a
(b) General nature of industry, business, or establishment in which employed (or employer): lumber yard.

9-BIRTHPLACE, (State or Country). Virginia.

PARENTS.

10-NAME OF FATHER, Absalom Young.(C).

11-BIRTHPLACE OF FATHER (State or Country). Virginia.

12-MAIDEN NAME OF MOTHER Rebecca Young.(C).

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thornton Young (C).(brother)

(Address) 1514 Carter Street.

15- ROBERT J KRAUTER

Filed AUG 24 1920 191 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 20th. 1920. (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and from his inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the Skull.
Accidental fall from a pile of lumber.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M Reinhardt M. D. (Coroner.)

Aug. 23rd., 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel Cem	8/24/ 1920
20-UNDERTAKER	ADDRESS
Jos H Trader	142 N Bell

N. B.—Every item of information should be carefully given, so that it may be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be intelligible. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1060 Bks.

1045944

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045944

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mass St. Not Wash (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelina Baltzman

(a) RESIDENCE. NO. Mass St. Not Wash ST.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Aug. 19/20.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant. nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Walter Rothman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary Hensel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Walter Rothman
(Address) Mt Washington

15 Filed AUG 24 1920 ROBERT F. KLAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23. 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1920, to Aug 23, 1920, that I last saw her alive on Aug 23, 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth.
(6 mo)

(duration) — yrs. — mos. — ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Raymond Klaus, M. D.

. 19 (Address) Fallstaff

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Aug 24 1920
20 UNDERTAKER William Cook	ADDRESS 503 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Novak

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45945

CERTIFICATE OF DEATH.

28 D45945

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 E. Lombard ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J. Novak.

(a) RESIDENCE. No. 2000 E. Lombard ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Julia Novak

6 DATE OF BIRTH (month, day, and year) Don't Know.

7 AGE: Years 43 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Gilder
(b) General nature of industry, business, or establishment in which employed (or employer): Picture frame
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Joseph Novak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Don't Know

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant (Address): Julia Novak 2000 E. Lombard
ROBERT F. LEAUTER

15 Filed AUG 24 1920 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1920, to Aug 20, 1920, that I last saw him alive on Aug 20, 1920, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about (duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Marlin E. Olson, M. D.

8 23, 1920 (Address) 415 Professional Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Aug 26 1920

20 UNDERTAKER: William Cook — ADDRESS: 502 E. North Ave

nation should be entered in plain terms, so that it may be properly classified. Each question must be answered. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. TION is very important. See instructions on back of certificates.

Dr. Olson - Professional Bldg. 320 N. Eutaw St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045946

HEALTH DEPARTMENT—CITY OF BALTIMORE.

1045946

CERTIFICATE OF DEATH.

104-04

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2228 Reed St. 1 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Rabula

(a) RESIDENCE. No. 2228 Reed St. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER George Rabula

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Julia Mickel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania

14 Informant George Rabula
(Address) 2228 Reed St

Filed AUG 24 1920 19 ROBERT I. KEATTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1920, to Aug 23, 1920, that I last saw h~~e~~r alive on Aug 23 1920, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Cholera Infantum

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? at place death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) W. H. Krammes M. D.

19 (Address) 1707 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cemetery	Aug 25 1920
20 UNDERTAKER	ADDRESS
H. Sander & Son	1710 Fleet St.

1707 E Baltimore St

REGISTRATION BLANKS should be filled out in ink, so that it may be properly classified. Fill out all items. Write plainly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Fill out all items. Write plainly. TION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L045947 28 L045947

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH 1835 Vine St.

CITY OF BALTIMORE: (No. 1835 ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Evelyn Epps.

(Residence in Baltimore: No. 1835 Vine St. St.: 10 yrs., mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, Aug 3, 1910
(Month) (Day) (Year)

7-AGE, 10 yrs. mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Edwin Epps.

11-BIRTHPLACE OF FATHER (State or Country), Wilmington Delaware

12-MAIDEN NAME OF MOTHER Cora Stafford

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cora Epps.

(Address) 1835. Vine st

15- AUG 24 1920 ROBERT P. FOSTER
Filed....., 191..... Registrar.
Burial Permit

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 22, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 16th 1920., to August 22nd 1920, that I saw her alive on On Aug 21st 1920, and that death occurred, on the date stated above, at 9-0- m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(Duration) yrs. mos. ds.

(Signed) Emmett Logue M. D.

Aug 23 1920 (Address) 714 Dolphin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Aug. 24th, 1920

20-UNDERTAKER Samuel McChase-sm — ADDRESS 1400. Mosher st

Dec. 6-9-19—H. P. Co.—1000 Bks.

1045948 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045948

CERTIFICATE OF DEATH. 43

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 Bloom ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Scales

(a) RESIDENCE. NO. 518 Bloom ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced (or) WIFE of Lawson Scales

6 DATE OF BIRTH (month, day, and year) April 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of Industry, business, or establishment in which employed (or employer) Laundry wrk

(c) Name of employer

9 BIRTHPLACE (city or town) Stokes Co
(State or country) N. C.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Unknown.
(State or country) Not known

14 Informant Liliam Hart
(Address) 1635 Millemon

15 Filed AUG 24 1920 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1920

17 I HEREBY CERTIFY, That I attended deceased from February 10 1920, to Aug 21, 1920, that I last saw her alive on Aug 20, 1920, and that death occurred, on the date stated above, at 11.40 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. William Frey, M. D.

9/21, 1920 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Aug 24 1920
20 UNDERTAKER David D Handley	ADDRESS 516 E Baltimore

ROBERT B. KRAUTER
Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045949

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045949

CERTIFICATE OF DEATH.

REGISTERED NO. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2413 E Preston ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E Knauer

(a) RESIDENCE. NO. 2413 E Preston ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 3rd 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER Maurice Knauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Annie Roethlingshofer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md

14 Informant Mr M Knauer

(Address) 2413 E Preston

15 Filed AUG 24 1920 19.. ROBERT E KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 19 20

17 I HEREBY CERTIFY, That I attended deceased from Aug 17th 20 19.., to Aug 24th 20 19.., that I last saw h.. alive on Aug 24th 20 19.., and that death occurred, on the date stated above, at 1 9. m.

The CAUSE OF DEATH* was as follows:

Pertussis Enteritis Catarrh

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W W Stone, M. D.

19 (Address) 1801 E Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Aug 24 1920
20 UNDERTAKER Henry Hauck & Son	ADDRESS 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2045950 2045950

CERTIFICATE OF DEATH. Baltimore. 109

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pleasant & Fairview Ave ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorathy A. Rossi

(a) RESIDENCE. No. Pleasant & Fairview Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Aug. 18 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt. Md
(State or country)

PARENTS

10 NAME OF FATHER John Rossi

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Rosa Gagliardi

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Mr. John Rossi
(Address) Pleasant & Fairview Ave

15 Filed AUG 24 1920 ROBERT I. FRAZIER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23d 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1920, to Aug 23, 1920, that I last saw h[illegible] alive on Aug 23, 1920, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob Frazier M. D.

1920 (Address) 1823 N Wash St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery.	Aug. 25 1920
20 UNDERTAKER Henry Storch Son	ADDRESS 1301 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE OF BIRTH is very important. See instructions on back of certificates.

D45951 HEALTH DEPARTMENT—CITY OF BALTIMORE D45951

154

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1 Fair Oaks Ave ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Erdman

(Residence in Baltimore: No. 1 Fair Oaks Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, November 22, 1838
(Month) (Day) (Year)

7-AGE, 91 yrs. 9 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Bamberger

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER, Catherine Whitesford

13-BIRTHPLACE OF MOTHER (State or Country), Md. Unk

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M. E. Erdman
(Address) Glenarm Md

15- Filed AUG 24 1931 ROBERT E. KRAUTER Registrar.
Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 25, 1931
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. Onsley M. D.
(Coroner)
(Address) 3 E Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Mary's Cemetery (Govans) | DATE OF BURIAL, Aug. 25, 1931

20-UNDERTAKER, Henry Storck & Son | ADDRESS 1301 E Eager St

N. B.—Every item of information should be carefully considered, that it may be properly classified. Exact statement of occupation, CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0 45952

HEALTH DEPARTMENT—CITY OF BALTIMORE

0 45952

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1135 Hollins ST.: 18 WARD)

2-FULL NAME Frank Giffin

(a) RESIDENCE. NO. 1135 Hollins ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 2 1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O R. R.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER George W. Giffin

11 BIRTHPLACE OF FATHER (city or town) Washington
(State or country) D. C.

12 MAIDEN NAME OF MOTHER Mary Ann Bentley

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Mrs. Mary E. Burman
(Address) 1135 Hollins St.

15 Filed AUG 24 1920 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1920

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1920, to Aug 21, 1920, that I last saw him alive on Aug 21, 1920, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Epithelioma of face. "Left Side"

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) Bernard J Faupel, M. D.

8/23, 1920 (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Aug 24 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every question must be answered. Write plainly with pen and ink. Use no abbreviations. Do not use "Unknown" if it is possible to obtain the information. DATE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L045953

L045953

CERTIFICATE OF DEATH.

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1024 N. Eutaw ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanch Elizabeth Harrison

(a) RESIDENCE. NO. 1024 N. Eutaw ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Robert E. Harrison

6 DATE OF BIRTH (month, day, and year) Aug. 8

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28	—	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Kidd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Susan Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Robert E. Harrison
(Address) 1024 N. Eutaw St

15 Filed AUG 24 1920 LOBEY Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22, 1920

17 I HEREBY CERTIFY, That I attended deceased from April 10th 1920, to Aug. 22nd. 1920, that I last saw h.. alive on Aug 22 . 1920, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) — yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) N. H. Pelletreau, M. D.

, 19 (Address) 817 Hamilton Ter.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 24 1920
20 UNDERTAKER Joseph B. Curtis	ADDRESS 1003 W Balto St

mation should be given in plain terms, so that it may be properly classified. Particularly must CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45954 HEALTH DEPARTMENT—CITY OF BALTIMORE D45954

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 E Barney ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys A Bradley

(a) RESIDENCE. NO. 125 E Barney ST., 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 23/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Butts Co. Ga.

PARENTS

10 NAME OF FATHER James L. Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Winchester Va

12 MAIDEN NAME OF MOTHER Mary Kepper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ala.

14 Informant James L. Bradley
(Address) 125 E Barney St

15 Filed AUG 24 1920 19 BOWERY Registrar

Burial Permit Issued Other

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1920, to Aug 23 1920

that I last saw her alive on Aug 23 1920

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. / ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. P. K. Campbell M. D.

Aug 20 1920 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	8/24 1920
20 UNDERTAKER	ADDRESS
J. F. M. Cully	130 E. Fayt.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact TION is very important. See instructions on back of certificates.

D 45955

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45955

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital ST. 7 WARD)

REGISTERED No. C 172

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Otto Slaich.

(Residence in Baltimore: No. 933 n castle St.; (yrs.) 28 (mos.) (ds.))

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July (Month) 21 (Day), 1883 (Year)

7-AGE, 37 yrs. 4 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Painter
(b) General nature of industry, business, or establishment in which employed (or employer). House

9-BIRTHPLACE, (State or Country). Bohemia

PARENTS.

10-NAME OF FATHER. Wences. Slaich

11-BIRTHPLACE OF FATHER (State or Country). Bohemia

12-MAIDEN NAME OF MOTHER Mt Kroun

13-BIRTHPLACE OF MOTHER (State or Country). Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Slaich

(Address) 933 N. Castle St

15- Filed AUG 24 1920, 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism of Skull

Instant (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J K Bouslog, (Coroner.) M. D.

Aug 24, 1920 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Hill — DATE OF BURIAL, Aug 24 1920

20-UNDERTAKER Frank Evach & Son — ADDRESS 1926 Eastlond Av

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45956 — 80 — D45956

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 McElderry ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cora Walker

(Residence in Baltimore: No. 1206 McElderry St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widow

6-DATE OF BIRTH, ? (Month) ? (Day) 1882 (Year)

7-AGE, 40 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Elijah Sharp

11-BIRTHPLACE OF FATHER (State or Country), Balto, Md.

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Dunscomb

(Address) 1206 McElderry St.

15- [illegible]

Filed AUG 24 1920 [illegible] Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 21 (Day), 1920 (Year)

17-I HEREBY CERTIFY, That I attended deceased from 7/21/1920, to 7/21/1920, that I saw h[illegible] alive on 7/21/1920, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

about 2

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) ... yrs. ... mos. ... ds.

(Signed) Clifford Byrd M. D.

8-24, 1920 (Address) 425 N. Carolina St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel

DATE OF BURIAL, Aug 24 1920

20-UNDERTAKER John W Henderson

ADDRESS 1502 E Monument St

D45957

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D45957

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2027 Clifton Ave. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Conrad Ziegler

(Residence in Baltimore: No. 2027 Clifton Ave St. 30 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	white	Married

6-DATE OF BIRTH: Nov (Month) 27 (Day) 1868 (Year)

7-AGE: 51 yrs. 8 mos. 25 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Butcher 013
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Unknown.

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Neuder & Summerfield Family

(Address) 2027 Clifton Ave

15- Filed AUG 24 1920 ROBERT A KRAUTER REGISTRAR

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Aug (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 22, 1919, to Aug 22 1920, that I saw him alive on August 21 1920, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Regurgitation

(Duration) 1 yr. ..... mos. ..... ds.

Contributory (SECONDARY) Mitral Stenosis

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) William J Burger M.D.

Aug 23, 1920 [Address] 2027 Clifton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge — DATE OF BURIAL: Aug 25 1920

20-UNDERTAKER: Robert S Settle — ADDRESS: 531 N Fremont Ave

N. B.—Every item of information should be carefully supplied. Data must be properly classified, so that it may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45958 HEALTH DEPARTMENT—CITY OF BALTIMORE D45958

CERTIFICATE OF DEATH. 5 - 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1233 Mulligan ST.; 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Jackson

(a) RESIDENCE. NO. 1233 Mulligan ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Jackson.

6 DATE OF BIRTH (month, day, and year) March 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Thos. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant James Jackson

(Address) 1233 Mulligan St

15 Filed AUG 24 1920 ROBERT T. NORRIS Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21. 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 13. 1920, to Aug. 21 1920, that I last saw h e alive on Aug. 21 1920, and that death occurred, on the date stated above, at 10 45 P. m.

The CAUSE OF DEATH* was as follows:

Pulm Tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Place of death.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Pulm. Hemorrhage & Physical Signs.

(Signed) Sol. C. Katz M. D

8/23 1920 (Address) 116 Hisquiah St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	Aug 25 1920
20 UNDERTAKER	ADDRESS
Chas. H. Johnson	467 N. Caroline

Burial Permit Issued

mation should be carefully written in ink, and in unusually legible hand-writing, preferably by a physician, so that it may be properly classified. Enter statements of CAUSE OF DEATH in plain terms, so that it may be understood by the laity. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45959

HEALTH DEPARTMENT—CITY OF BALTIMORE

1460 D45959

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.: 75 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marcus Lachman

(a) RESIDENCE. No. Curtis Bay St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child of Samuel Lachman

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	13	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel Lachman

11 BIRTHPLACE OF FATHER (city or town) (State or country) ~~Russia~~ Russia

12 MAIDEN NAME OF MOTHER Celia Ring

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant..... (Address) J. Levy 1411 E Balto St

15 Filed ..... 19 AUG 24 1920

BOBERT B. LATHEN Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/23 1920

17 I HEREBY CERTIFY, That I attended deceased from August 21, 1920, to August 23, 1920, that I last saw him alive on August 23, 1920, and that death occurred, on the date stated above, at 3:50 P.m.

The CAUSE OF DEATH* was as follows:

Primary cause. Osteomyelitis of left tibia

Contributory cause. Septicemia

3 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia

2 Days (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/21/20

Was there an autopsy? No

What test confirmed diagnosis? operation, Inspection

(Signed) L. H. Brumback M. D

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	8/24 1920

20 UNDERTAKER Jack Levy

ADDRESS 1411 E Balto St

mation should be carefully supplied, so that it may be properly classified. Full statement of CAUSE OF DEATH in plain terms

Spec.—8-24-14—M. & T.—2000 Bks.

D45960

HEALTH DEPARTMENT—CITY OF BALTIMORE

29 D45960

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 433 Yale, ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian A Schmidt

(Residence in Baltimore: No. 433 Yale St.; 16 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
female.	white	Single

6-DATE OF BIRTH. March 10, 1904 (Month) (Day) (Year)

7-AGE. 16 yrs. 4 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stenographer do
(b) General nature of industry, business, or establishment in which employed (or employer): Drug house

9-BIRTHPLACE. (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Rudolph Schmidt

11-BIRTHPLACE OF FATHER (State or Country). Balto Md.

12-MAIDEN NAME OF MOTHER Catherine E. Baar

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. J. Schmidt

(Address) 633 Yale Ave

15-

Filed AUG 24 1920, 191.... ROBERT E. LEE, Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug 20, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1919, to Aug 20 1920, that I saw h-r alive on Aug 20 1920, and that death occurred on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary tuberculosis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(Duration) yrs. mos. 6 ds.

(Signed) R. J. Schmidt M. D.

Aug. 21, 1920 (Address) 1002 W. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Aug 24, 1920
20-UNDERTAKER	ADDRESS
Geo Leinhardt	647 N Eutaw

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45961

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45961

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Powell Ave. Raspberry St.; W 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Linsey

(a) RESIDENCE. NO. 12 Powell Ave. ST. Raspberry WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 24th 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George H Linsey

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Dolk

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant George Linsey (Address) Raspberry St

15 Filed AUG 24 1920 ROBERT N. CARTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1920

17 I HEREBY CERTIFY, That I attended deceased from July 27. 1920. to Aug 22. 1920. that I last saw h[e] alive on Aug 22 1920. and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Tubercular Cutivitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wm Pirquet test. X ray

(Signed) Dr Bernard Lowe, M. D.

(Address) 914 E Biddle St

8/23 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 20 1920
20 UNDERTAKER	ADDRESS
Fred Lissahan & Son	Fulerton Md.

N. B.—WRITE PLAINLY. All items should be carefully supplied. Attention is called to the fact that it may be properly classified. Exact statement of occupation should be given. CAUSE OF DEATH in plain terms, so

Spec.—8-24-14—M. & T.—2000 Bks.

D45962 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D45962

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Marie Smith St.; 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME 1804 Laurens St.

(Residence in Baltimore: No. 1804 Laurens St.; ..... yrs., 7 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 6 (Day), 1920 (Year)

7-AGE, ... yrs. 7 mos. 23 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Wm. J. Smith

11-BIRTHPLACE OF FATHER (State or Country), St. Mary's Co. Md.

12-MAIDEN NAME OF MOTHER Christina Hardy

13-BIRTHPLACE OF MOTHER (State or Country) St. Mary's Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. J. Smith

(Address) 1804 Laurens St.

15- AUG 24 1920 LOUIS B KRAUTER
Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 20 1920, to Aug. 23 1920, that I saw h[illegible] alive on Aug. 23 1920, and that death occurred, on the date stated above, at 12 1 m.

The CAUSE OF DEATH* was as follows:

Enteritis

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John D. Heuisler M. D.

Aug 23 1920 (Address) 1502 W. Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, H Lot

DATE OF BURIAL, Aug 24 1920

20-UNDERTAKER Samuel Ewing

ADDRESS 1364 Carey

N. B.—Every item of answer must be properly entered, so that it may be plain terms, so that it may be important. See instructions on back of certificate.

CAUSE OF DEATH

Spec.—8-24-14—M. & T.—2000 Bks.

Coles.

D45963

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45963

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 Preston ST.; 11 WARD)

REGISTERED No. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Parker

(Residence in Baltimore: No. 314 Preston St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, 1868 – (Month) (Day) 1 (Year)

7-AGE, 52 yrs. 7 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) Engineer

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ruth Parker

(Address) 314 Preston St

15- AUG 24 1920 Filed, 191 ROBERT P. BRAUER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 23d, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 22 1920, to Aug 23 1920, that I saw h[illegible] alive on Aug 23 1920, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Acute Mania

(Duration) 72 hrs

CONTRIBUTORY (Secondary) Nephritis

(Duration) 3 yrs mos ds.

(Signed) A. Jem Ellis M. D.

924 1920 (Address) 924 N Mon

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters

DATE OF BURIAL, Aug 25, 1920

20-UNDERTAKER Emmert & Wright

ADDRESS 1361 W Cary

N. B.—Every item must be properly answered, so that it may be CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20459 64 HEALTH DEPARTMENT—CITY OF BALTIMORE 20459 64

CERTIFICATE OF DEATH. 4 X 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hosp. (St.) 4 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Gale ?

(a) RESIDENCE. NO. ? ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 16, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Edward Gale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Pa.

14 Informant (Address) AUG 24 1920 Robert P. Harrison,

15 Filed . 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/16 1920

17 I HEREBY CERTIFY, That I attended deceased from 8/16, 1920, to 8/16, 1920, that I last saw him alive on 8/16, 1920, and that death occurred, on the date stated above, at 3,10 P m.

The CAUSE OF DEATH* was as follows:

Syphilitic Aortitis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Regurgitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy Findings

(Signed) Wm. A. Reddy, M. D.

8/22 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mercy Hosp.	Aug 28 1920
20 UNDERTAKER	ADDRESS

mation should be carefully supplied. Exact statement of DECEASED'S
CAUSE OF DEATH in plain terms, so that it may be properly classified.
DON is very important. See instructions on back of certificates.

17456

Spec.—6-9-19—H. P. Co.—1000 Bks.

William D. Stewart

D. 45 965

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 45 965

1047

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2835 Remington Ave. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William D. Stewart

(a) RESIDENCE. No. 2835 Remington Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of x

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work x

(b) General nature of industry, business, or establishment in which employed (or employer) x

(c) Name of employer x

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William D. Stewart

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Lula Stokes

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant William H. Stewart
(Address) 2835 Remington Ave.

15 Filed AUG 24 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24/20 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1920, to Aug 24, 1920, that I last saw h... alive on Aug 23, 1920, and that death occurred, on the date stated above, at 8 22 A m.

The CAUSE OF DEATH* was as follows:
Acute Gastro Enteritis

(duration) ... yrs. ... mos. 25 ds.

CONTRIBUTORY (Secondary) Bronchitis Chronic

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? x Date of x

Was there an autopsy? No

What test confirmed diagnosis? Typical Signs

(Signed) Jesse S. Bell, M. D.

19 (Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Aug 25 1920
20 UNDERTAKER	ADDRESS
Felix B. Pye	102 S. Mulberry St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Last statement of cause of death must be signed by physician. See instructions on back of certificates.

Biernatowski

D.45966 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45966

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 335 Dawson ST. 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Biernatowski

(Residence in Baltimore; No. 335 Dawson St.; Yrs., mos., ds.) 20

N. B.—Every item of information should be carefully supplied. AGE should be filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, Not Known 1 (Month) (Day) (Year)

7-AGE: 47 yrs. 0 mos. 0 da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 640
(b) General nature of industry, business, or establishment in which employed (or employer): Manufacturing

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Joseph Biernatowski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Rozalia Prankowski

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Abe Biernatowski

(Address) 335 Dawson St.

15-
Filed AUG 24 1920, 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 21, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Hall Kuschke M. D.
(Coroner)

(Address) 120 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Aug 25 1920

20-UNDERTAKER Wm Hawkins — ADDRESS 1618 Eastern

Spec.—8-24-14—M. & T.—2000 Bks.

D.45967 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45967

CERTIFICATE OF DEATH. 135 1

1-PLACE OF DEATH REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 802 S. Lakewood ave ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michalina ~~Pikut~~ Pikut

(Residence in Baltimore: No. 802 S. Lakewood ave. St.; 10 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F.	W.	Married

6-DATE OF BIRTH, ... august (Month) 5 (Day) 1882 (Year), 1 .....

7-AGE, 38 yrs. — mos. 18 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... House wife .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... —

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, anthony Jaselbas

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Christina Jerocha

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Pikut

(Address) 802 S Lakewood ave

15- Filed AUG 24 1920, 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug (Month) 23 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Aug 23 1920, to Aug 23 1920, that I saw h[er] alive on Aug 23 1920, and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Post partum Haemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Aug 24, 1920 (Address) 1804 Eastern ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, aug. 26..., 1920

20-UNDERTAKER John F. Weber — ADDRESS 1803 Bank St

N. B.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Data must be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45968

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45968

642

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Marlborough Apts. ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Gelt

(Residence in Baltimore: No. Marlborough apt. St.; 79 yrs., 1 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, June (Month) 9th (Day), 1841 (Year)

7-AGE, 79 yrs. 1 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Myer Steigerwald

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose M Gelt

(Address) Marlborough Apts

15-

Filed AUG 24 1920, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 23 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Aug 23 1920, that I saw h[er] alive on Aug 23 1920, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Ileus - 2 days

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Apoplexy

..... (Duration) ..... yrs. ..... mos. 5 ds.

(Signed) J Frederick Lutz M. D.

8/23, 1920. (Address) 7 W Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew cem

DATE OF BURIAL, 8/25, 1920

20-UNDERTAKER J. A Krems Co

ADDRESS 1611 Monument

N. B.—Every blank must be filled. Every item of information should be given. Every CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45969

1347 1934 D.45969

CERTIFICATE OF DEATH.

× 150

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Boulin

(a) RESIDENCE. No. Greenville, S. C. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. 6 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): S. C.

PARENTS

10 NAME OF FATHER Robert Boulin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Texas

12 MAIDEN NAME OF MOTHER Margery Murrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Texas

14 Informant: Hospital Record
(Address): J. H. H.

15 Filed AUG 24 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 18, 1920, to Aug 24, 1920, that I last saw her alive on Aug 24, 1920, and that death occurred, on the date stated above, at 12 5 P m.

The CAUSE OF DEATH* was as follows:

Congenital hydrocephalus

(duration) ... yrs. 4 mos. 17 ds.

CONTRIBUTORY (Secondary): none

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 24, 1920

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Harold L. Higgins M. D.

8-24-1920 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rogersville Tenn	Aug 24 1920
20 UNDERTAKER	ADDRESS
Wm C. Black	927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL BLANKS must be filled. PHYSICIANS must state mation should be carefully supplied. AGE should be stated EXACTLY. OCCUPATIONS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D.45970 HEALTH DEPARTMENT—CITY OF BALTIMORE D.45970

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Maryland Gen. Hospital ST.) 17 WARD) 167 REGISTERED No. C.....

2-FULL NAME Abe Singleton

(Residence in Baltimore: No. 331 N. Twentieth St.; 8 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Unknown

6-DATE OF BIRTH, Unknown, 1896
(Month) (Day) (Year)

7-AGE, 24 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) (Steel)

9-BIRTHPLACE, (State or Country), Georgia

PARENTS.

10-NAME OF FATHER, Stanley Singleton

11-BIRTHPLACE OF FATHER (State or Country), Georgia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bethlehem Steel Co.

(Address) Steelton, Md.

15- Robert P. Harrison,

Filed AUG 24 1920, 191.....
Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH August 22, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Burns received accidently, while working at Bethlehem Steel Co.) (Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Second degree burns of leg & body

(Duration) yrs. mos. 10 ds.

(Signed) Jas. T. Hennessy M. D.
(Coroner.)

August 23 1920 (Address) 2902 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death Md. Gen. Hosp. yrs. mos. 10 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Bethlehem Steel Co. (Steelton, Md.)

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Savannah Ga — DATE OF BURIAL, Aug 24 1920

20-UNDERTAKER John F. Denny — ADDRESS 715 Light

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45971 D.45971 D.45971/20

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1828 McHenry ST.; 19 WARD)

2-FULL NAME Mrs Louise McCarthy

(a) RESIDENCE. No. 1828 McHenry WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of July 30. 1848

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72 yrs.		24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Enreka Springs
(State or country) Arkansas

PARENTS

10 NAME OF FATHER James Gordon

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Charles C. Carr
(Address) 1828 McHenry St.

15 Filed AUG 24 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1920
Aug 24. 1920

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1920, to Aug 24, 1920,
that I last saw her alive on Aug 24, 1920,
and that death occurred, on the date stated above, at 10.20 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis 2
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fatty Degeneration of Heart (duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Dr Theodore Lacey M. D.

Aug. 24 1920 (Address) 3450 Fieldcrest Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D C	Aug 26 1920
20 UNDERTAKER William Cook	ADDRESS 502 E Nall

N. B.—Blanks should be carefully supplied. AGE should be stated accurately. Exact statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.45972

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45972

45V

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 Tramore Road Ward 24) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R Edwards

(a) RESIDENCE. No. 220 Tramore Road ST., WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L Edwards

6 DATE OF BIRTH (month, day, and year) March 16 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 067

(b) General nature of industry, business, or establishment in which employed (or employer) Night Watchman

(c) Name of employer Charles Co

9 BIRTHPLACE (city or town) Charles Co
(State or country) Md

PARENTS

10 NAME OF FATHER John Edwards

11 BIRTHPLACE OF FATHER (city or town) Charles Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) Charles Co
(State or country) Md

14 Informant Mary L Edwards
(Address) 220 Tramore Road

15 Filed AUG 24 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 19 20, to Aug 24, 19 20,
that I last saw h[illegible] alive on Aug 24, 19 20,
and that death occurred, on the date stated above, at 8 20 a. m.
The CAUSE OF DEATH* was as follows:

1st Carcinoma of Tongue

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of both hands

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

8/24 19 21 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Mem't	Aug 26 1920
20 UNDERTAKER	ADDRESS
Wm Cook Sons & Smith	

N. B.—WRITE PLAINLY, WITH [illegible]. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.45973

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45973

CERTIFICATE OF DEATH.

REGISTERED NO. C 402

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 Keyser St.; 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Mann

(Residence in Baltimore: No. 1628 Keyser St.; 44 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, October 23, 1875 (Month) (Day) (Year)

7-AGE, 44 yrs. 10 mos. — ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Isaac P. Mann

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Sarah Hamilton

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST ~~OF~~ MY KNOWLEDGE.

(Informant) Mildred Funk

(Address) 149 S. Eastern

15- Filed Aug 24 1920, 191... Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 23, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1st 1920 to August 23 1912, that I saw h[illegible] alive on August 18th 1920, and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) ... yrs. 11 mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ... yrs. ... mos. ... ds.

(Signed) D. E. Lilly M. D.

Aug 23 1920 (Address) 8 W. Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill — DATE OF BURIAL, Aug. 25, 1920

20-UNDERTAKER William Cook — ADDRESS 502 E. North

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.45.974 D.45.974

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1820-N Spring St.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Douglas Young

(Residence in Baltimore: No. 1820 N Spring St.; 1 yrs., X mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, Aug (Month) 1 (Day), 1919 (Year)

7-AGE, 1 yrs. X mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... X
(b) General nature of industry, business, or establishment in which employed (or employer)..... [illegible]

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Wm Young

11-BIRTHPLACE OF FATHER (State or Country), Balto County Md

12-MAIDEN NAME OF MOTHER Mamie Garner

13-BIRTHPLACE OF MOTHER (State or Country), St Mary's County Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Young

(Address) 1820 N Spring

15- Robert P. Harrison, Registrar.

Filed....., 191.....

AUG 24 1920 Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 24 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from AUG 20 1920 191, to AUG 23 1920 191, that I saw h IM alive on AUG 23 1920 191, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Dyspepsia

(Duration) X yrs. X mos. 2 ds.

CONTRIBUTORY (Secondary) Gastro-Enteritis

(Duration) X yrs. X mos. 10 ds.

(Signed) D H Duke M. D.

AUG 24, 1920 191... (Address) 928 E. NORTH AVE

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel	Aug 25..., 1920
20-UNDERTAKER William Cook	ADDRESS 502 S. North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45975 HEALTH DEPARTMENT—CITY OF BALTIMORE D45975

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: No 809 N. Appleton ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Llewellyn Thomas Hudgins

(a) RESIDENCE. No. 809 N. Appleton ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude J Hudgins

6 DATE OF BIRTH (month, day, and year) Dec 28 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER Mos. E. Hudgins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary A Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Gertrude J. Hudgins

(Address) 809 N. Appleton St

15 Filed AUG 25 1920 ROBERT P. [illegible] Registrar

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1920

17

I HEREBY CERTIFY, That I attended deceased from Mar 2, 1920, to Aug 21, 1920,

that I last saw him alive on Aug 21, 1920,

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? 809 N Appleton

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & chemical

(Signed) Walter E. Hitchcock M. D.

, 19 (Address) 2002 W. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Aug 25 1920
20 UNDERTAKER Wm Tuckner & Son	ADDRESS North & Pa

mation should be carefully supplied. Each statement should be complete so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement should be complete so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1045976

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045976

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO. Old Springhouse ST.: 29 WARD)

2-FULL NAME Henry B. Whipple

(a) RESIDENCE. NO. Old Springhouse ST., 29 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Alice L. Whipple

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	90			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Wool Dye Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pawtucket R.I. U.S.

PARENTS

10 NAME OF FATHER - Henry Whipple

11 BIRTHPLACE OF FATHER (city or town) Smithfield (State or country) R.I. U.S.

12 MAIDEN NAME OF MOTHER Clara Lapham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) R.I. U.S.

14 Informant Edward F. Whipple
(Address) Old Springhouse Lane.

15 Filed AUG 25 1920 ROBERT J. SLATER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/24 1920

17 I HEREBY CERTIFY, That I attended deceased from 8/23 1920, to 8/24 1920, that I last saw him alive on 8/23 1920, and that death occurred, on the date stated above, at 4.00 p. m.

The CAUSE OF DEATH* was as follows: (Accidental Death)

Myocardial Degeneration
Arteriosclerosis

CONTRIBUTORY (Secondary) (duration) yrs. 6 mos. ds.

Pneumonia Congestion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —above

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dept of Com Coroner

(Signed) Henry F. Cockey, M. D.

, 1920 (Address) Roland Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M.C. Woodlawn Cem	Aug 26 1920
20 UNDERTAKER	ADDRESS
H. G. Tickner & Son	Bath St

N. B. Information should be carefully supplied and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045977 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045977

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2320 Division ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Lewis

(a) RESIDENCE. No. 2320 Division ST., WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

3a If married, widowed, or divorced
BUSBAND of
(or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE 70 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED Domestic

(a) Trade, profession or particular kind of work 70

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co
(State or country) md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Lizzie Thomas
(Address) 2320 Division St

15 Filed . 19 Registrar
AUG 25 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 5 . 1920, to Aug 24 . 1920, that I last saw her alive on Aug 23 . 1920, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. William Frey, M. D.

8/27. 1920 (Address) 1918 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Aug 26 1920
20 UNDERTAKER	ADDRESS
Joseph A Farrell	2314 Division

N. B.—WHITE PAPER, BLACK INK. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

1045978

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045978

CERTIFICATE OF DEATH.

REGISTERED NO. 792

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 Wendell ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Ann Kraft

(a) RESIDENCE. NO. 1422 Wendell ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Thomas F. Kraft.

6 DATE OF BIRTH (month, day, and year) Nov. 13, 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	9	7.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 920

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Peter H. Kraft.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Marguite Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France.

14 Informant Maggie Emerson
(Address) 1204 Lexington

15 Filed AUG 25 1920 ROBERT J. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1920, to Aug 24, 1920.

that I last saw her alive on Aug 24, 1920,

and that death occurred, on the date stated above, at 12.05 [illegible]

The CAUSE OF DEATH* was as follows:

Cardiac Degeneration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Seabury, M. D.

8/24, 1920 (Address) 638 Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	aug 25 1920
20 UNDERTAKER William Cook	ADDRESS 502 E Fath. ave

N. B.—WRITE PLAINLY. All questions should be carefully answered. Information should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

1045979 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045979

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. #2425 N. Calvert Street ST.; 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cyril Warren Keech.

(Residence in Baltimore: No. #2425 N. Calvert Street. St.: 67 yrs. 11 mos. 8 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, September (Month) 15 (Day), 1852 (Year)

7-AGE, 67 yrs. 11 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Accountant

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Cyril Warren Keech

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Rachel I. Glascow

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Grace G. Keech (daughter)

(Address) #2425 N. Calvert St.

15- AUG 25 1920 ROBERT B KRAUTER

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) found that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) ..... M. D.

Aug 24 1920 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
GreenMount Cemetery	Aug/25/1920
20-UNDERTAKER STUART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1045980

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045980

CERTIFICATE OF DEATH.

104

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2816 Elliott ST.; 1 WARD)

2-FULL NAME Ernest F. Ford.

(a) RESIDENCE. NO. 2816 Elliott ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 18 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Ernest J. Ford.

11 BIRTHPLACE OF FATHER (city or town) Phila Pa.
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Dasch.

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country)

14 Informant Mother Minnie Ford
(Address) 2816 Elliott St.

15 Filed AUG 25 1920 ROBERT E. CRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23rd 1920

17 I HEREBY CERTIFY, That I attended deceased from 8. 22 1920, to Aug 23, 1920.

that I last saw h— alive on Aug 22, 1920.

and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Litton, M. D.

8/24, 1920 (Address) 2921 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Aug 25th 1920
20 UNDERTAKER Lilly + Zeiler	ADDRESS 403 S. Dolphin St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45981

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45981

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2318 Division ST.: 14 WARD)

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adalia Carporal

(a) RESIDENCE. No. 2318 Division ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Allen Carporal

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Liberty Baltimore Co. for Carroll Co. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) Unknown

14 Informant Mrs Carporal (Address) 2318 Division St.

15 Filed AUG 25 1920 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1919, to Aug. 22, 1920, that I last saw h[illegible] alive on Aug. 22, 1920, and that death occurred, on the date stated above, at 10-25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? appearance of urine

(Signed) Robert F. Green M. D.

8-24 1920 (Address) 120½ Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Aug 27 1920
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1723 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. Erasures, etc., CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2045982 HEALTH DEPARTMENT—CITY OF BALTIMORE 2045982

CERTIFICATE OF DEATH.

REGISTERED No. C 137

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 302 N. Hoffman St.: 11 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith Proctor

(Residence in Baltimore: No. 302 N. Hoffman St.; 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1898 (Year)

7-AGE, 22 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waitress
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Washington, D. C.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept.

(Address) North Western Dist

15- Filed AUG 25 1920 191 ROBERT B KRAUSE Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 22, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Puerperal Septicaemia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Abortion (not criminal)

(Duration) yrs. mos. ds.

(Signed) J. D. Hennessy M. D. (Coroner.)

August 24 1920 (Address) 2802 Edgemont Ave

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Aug 25 1920

20-UNDERTAKER David Taylor — ADDRESS 916 Lemmon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L45983

L45983

CERTIFICATE OF DEATH.

REGISTERED NO. 28 L45983

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 7 Temple ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Gross

(a) RESIDENCE. NO. 7 Temple ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) June 30 - 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer Unknown Baltimore Md

PARENTS

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER H Harry Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Maggie Thorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Maggie Gross (Address) 7 Temple

15 Filed ..... 19 ..... Registrar

AUG 25 1920 COUNTY E. FRANTZ

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1920, to Aug 23, 1920, that I last saw h... alive on Aug 22, 19..., and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Influenza

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm Burns, M. D.

Aug. 24, 1920 (Address) 2-1520 Mt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem

DATE OF BURIAL: Aug 25 1920

20 UNDERTAKER: Samuel Handy

ADDRESS: 27 N Bethel

N. B.—WRITE PLAINLY, with ink. All items must be stated. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified

Spec. 6-9-19—H. P. Co.—1000 Bks.

D45984 HEALTH DEPARTMENT—CITY OF BALTIMORE D45984

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH Baltimore 2nd

CITY OF BALTIMORE: (No. 246 Rock St., 18 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen E. Sloan

(a) RESIDENCE. NO. 246 Rock St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May 24/1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Walter Sloan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ella Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Walter Sloan (Address) 246 N. Rock St

15 Filed AUG 25 1920 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day) August 24 1920.

17 I HEREBY CERTIFY, That I attended deceased from July - 1920, to Aug 24 1920, that I last saw her alive on Aug 23 1920, and that death occurred, on the date stated above, at 3. P.M. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? -

(Signed) W H Ingram M. D.

. 19 (Address) 2439 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 25 1920

20 UNDERTAKER David T Hemsley ADDRESS 518 N Bond

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45985

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D45985

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 741 N. Kenwood Ave. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Rose Meekins

(a) RESIDENCE. No. 741 N. Kenwood Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be stated EXACTLY. PHYSICIANS are required by law to report at once to the Health Department all cases coming under their care. INFORMATION should be carefully supplied. AGE should be stated at last birthday. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 2, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William Andrew Meekins

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Anna E. Mitzel

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant William E. Mitzel
(Address) 741 N. Kenwood Ave.

15 Filed AUG 25 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1920, to Aug 23, 1920, that I last saw h[illegible] alive on Aug 23, 1920, and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation, Cardiac Exhaustion

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. B. Kluchen, M. D.

Aug 25, 1920 (Address) 5304 Brooklyn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cem (Hampden)	Aug 25 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45986

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45986

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital WARD 22)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Kuehne

(a) RESIDENCE. NO. 545 W. Conway St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch. 21, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records.

(Address)

15 Filed AUG 25 1920 ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24th, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 23rd, 1920, to Aug. 24th, 1920, that I last saw him alive on Aug. 24th, 1920, and that death occurred, on the date stated above, at 11.05 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) L. J. Rigney, M. D.

8/24 1920 (Address) Bay View Asylum.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery.	Aug 26 20
20 UNDERTAKER	ADDRESS
Wm. H. Fox	1723 W. Lafayette ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be stated EXACTLY. PHYSICIANS should be careful supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Bradley.

L045987

HEALTH DEPARTMENT—CITY OF BALTIMORE

L045987

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2202 Etting St.: 14 WARD)

2-FULL NAME Arthur Brodley.

(a) RESIDENCE. NO. 2202 Etting ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Bl	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Unknown 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nothing. 0

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Smith Brodley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Miles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Arthur Bradley 2202 Etting St.

15 Filed AUG 25 1920 ROBERT E. BEAUTE Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22 1920

17 I HEREBY CERTIFY, That I attended deceased from May 3 1918, to Aug 22 1920, that I last saw h m alive on Aug 22 1920 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows: Paralysis

(duration) 2 yrs. 3 mos. 15 ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

. 19 (Address) 1303 W North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Aug 25 1920
20 UNDERTAKER John H. Vondrine	ADDRESS 1424 Hill

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be careful in the statement of dates. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in the statement of dates. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage.

Churchill

1045988 HEALTH DEPARTMENT—CITY OF BALTIMORE 1045988

CERTIFICATE OF DEATH. 169

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ~~6330~~ Foot of Clinton St. 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Churchill

(Residence in Baltimore: No. 633 W Bdle St. St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Negro

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1883 (Year)

7-AGE 37 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Bailey

(Address) 1334 Bradley St

15- Filed AUG 25 1920 191.....

ROBERT B KRAUTER Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 20, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. Preston Mackey M. D. (Coroner)

Aug 25, 1920 (Address) 1800 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Aug 25 1920

20-UNDERTAKER John H. Soading — ADDRESS 142 W. Hill St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

045989 045989

REGISTERED NO. 15 54

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO. 1925 Dukeland ST.: WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Frederick Essig

(a) RESIDENCE. NO. 1925 Dukeland ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Sarah J Essig

6 DATE OF BIRTH (month, day, and year) August 27th 1845

7 AGE — Years: 74 | Months: 11 | Days: 27 | If LESS than 1 day, ...hrs. or ....min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired Butcher
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS
10 NAME OF FATHER: Frederick Essig
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Regina Kegler
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Sarah J Essig 1925 Dukeland ave

15 AUG 25 1920 ROBERT I. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8. 24 1920

17 I HEREBY CERTIFY, That I attended deceased from ~~Aug~~ July 20. 1920., to Aug 24. 1920.
that I last saw him alive on Aug 23. 1920 at 5.30 a. m.
and that death occurred, on the date stated above, at
The CAUSE OF DEATH* was as follows:
Pernicious Anemia
Said to be about 1 year
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A C Pole, M. D.
, 19 (Address) 2032 Madison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Aug 27th 1920
20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be stated EXACTLY. PHYSICIAN should be careful to see that AGE should be properly classified. Exact statement of OCCUPATION should be carefully supplied.

Spec.—8-24-14—M. & T.—2000 Blks.

1045990

HEALTH DEPARTMENT—CITY OF BALTIMORE

1045990

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2206 E Lanvale St.; 8 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Warren G. Wilson

(Residence in Baltimore: No. 2206 E Lanvale St. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W.	S

6-DATE OF BIRTH, June 20, 1920
(Month) (Day) (Year)

7-AGE, 0 yrs. 2 mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... X ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Brooklyn City

PARENTS.

10-NAME OF FATHER, Edward G Wilson

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Flora E Bocoe

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward G Wilson

(Address) 2206 E Lanvale

15- Filed AUG 25 1920, 191.. ROBERT F BRAUER Burial Permit 01544 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 23, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 13 1920, to Aug. 23 1920, that I saw him alive on Aug. 22 1920, and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Gastro-Intestinal auto-intoxication

Summer Diarrhoea.

(Duration) ....yrs. 10 mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Ernest G Lewis M. D.

Aug 23, 1920 (Address) 1 W 14 E Eager St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Aug 26, 1920
20-UNDERTAKER Robt J Turner	ADDRESS 1 W 21 St

N. B.—WRITE PLAINLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45991

D 45991

CERTIFICATE OF DEATH.

REGISTERED NO. C 28 D 45991

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 750 Graesche ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laurence Hurtt

(Residence in Baltimore: No. 750 Graesche St. 2 yrs. 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. Apr 8, 1908 (Month) (Day) (Year)

7-AGE. 12 yrs. 4 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Chas A. Hurtt

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Mary L. Green

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary L. Hurtt

(Address) 750 Graesche St.

15- AUG 25 1920 ROBERT F. BAUTER Registrar.
Filed ..... 191... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 24, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 7 1920, to Aug 24 1920, that I saw h in alive on Aug 24 1920, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

I Pulmonary Tuberculosis

contributory

(Duration) ..... yrs. ..... mos. ..... ds.

Wtg

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John L. Stewart M. D.

8/25/20 (Address) 704 W Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Aug 27, 1920

20-UNDERTAKER Chas H Hall & Son — ADDRESS 1631 Eutaw Pl

N. B.—Every item of information should be carefully considered, that it may be properly classified. Exact answers should be given to each question. In the CAUSE OF DEATH in plain terms, so that it may be understood by the public. Omissions are important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45992 D45992

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 Druid Hill Ave. WARD 14)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cordelia Oliver

(a) RESIDENCE. No. 1628 Druid Hill Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: x

6 DATE OF BIRTH (month, day, and year): 1834

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
86 yrs	"	"	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer): no

(c) Name of employer: no

9 BIRTHPLACE (city or town) (State or country): N C / N C

PARENTS

10 NAME OF FATHER: Burton Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country): N C

12 MAIDEN NAME OF MOTHER: Martha Broadnax

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N C

14 Informant: Mrs Maggie Elliott

(Address) 1628 Druid Hill Ave

AUG 25 1920 ROBERT [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 28 20 19

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1920, to Aug 25, 1920, that I last saw her alive on Aug 22, 1920, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows: Contributory Chronic Interstitial Nephritis and Heart Complications

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary): Age & Hardship

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physician's opinion

(Signed) Geo L Ball, M. D.

19 (Address) 1626 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	Aug 26, 1920

20 UNDERTAKER: Geo H Holland

ADDRESS: 1631 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS SHOULD WRITE EXACTLY. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 45993

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 45993

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 Ridgely St.; 21 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Robinson

(Residence in Baltimore: No. 1004 Ridgely St.; ..... yrs., ... mos. ..... ds.)

WRITE PLAINLY. PENCIL MAY BE USED.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Dec. (Month) 6 (Day), 1862 (Year)

7-AGE,	If LESS than 1 day,
57 yrs. 8 mos. 18 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Caspar Schmidt

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Barbara Koerich

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Robinson

(Address) 1004 Ridgely St

15-

Filed..... 191.....

AUG 25 1920 Burial Permit Issued

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 23 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 22 1920, to Aug 23 1920, that I saw her alive on Aug 23 1920 and that death occurred, on the date stated above, at 730 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremic coma

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) J. Finley Craig M. D.

Aug 25 1920 (Address) 729 Eutaw pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
London Park Cemetery	Aug 27 1920
20-UNDERTAKER James Dignan & Son	ADDRESS 1000 S Paca St

Spec.—8-24-14—M. & T.—2000 Bks.

D45994 HEALTH DEPARTMENT—CITY OF BALTIMORE D45994

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1016 S Paca St. ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose D. McCaffray

(Residence in Baltimore: No. 1016 S Paca St. St.; ....yrs.,....mos.....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Aug 8, 1899 (Month) (Day) (Year)

7-AGE, 21 yrs. mos. 16 dys. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Paul J. McCaffray

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Dora M. Bassett

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dora M. McCaffray

(Address) 1016 S. Paca st

15- ROBERT B KRAUTER

Filed AUG 25 1920 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 24, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1920, to Aug 24 1920, that I saw h.r alive on Aug 22 1920, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) ....yrs. 8 mos. ....da.

CONTRIBUTORY (Secondary) Cystitis

(Duration) ....yrs. 2 mos. ....da.

(Signed) J. M. Lemmon M. D.

Aug 24, 1920. (Address) 826 N. Durst St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cemetery	Aug 26, 1920
20-UNDERTAKER	ADDRESS
James Dignan & Son	1000 S. Paca St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH

Spec.—6-9-19—H. P. Co.—1000 Bks.

D45995 HEALTH DEPARTMENT—CITY OF BALTIMORE D45995

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1200 N Eugene Ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Frances Hennessy

(a) RESIDENCE. No. 1200 N. Eugene Ave ST.. WARD.

(Usual place of abode) dont

Length of residence in city or town where death occurred 7 yrs. 2 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 29 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pottsville Pa

PARENTS

10 NAME OF FATHER John J. Hennessy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire.

12 MAIDEN NAME OF MOTHER Mary Smyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mr Sherman F. Hennessy

(Address) 1200 N Eugene Ave

15 Filed AUG 25 1920 Burial Permit Given

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1920, to Aug 24, 1920.

that I last saw her alive on Aug 24, 1920.

and that death occurred, on the date stated above, at 2:30 a. m.

The CAUSE OF DEATH* was as follows:

Ascending Cancer of Colon

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathetic

(Signed) H. C. Hagner, M. D.

Aug 25, 1920 (Address) 1301 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia Pa.	Aug. 27 1920
20 UNDERTAKER Henry Schock Son	ADDRESS 1301 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful in stating the date of death. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating the date of death. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45996 — 10 D45996

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2509 E. Fayette ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robt J. Albiker

(a) RESIDENCE. NO. 2509 E. Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 7 mos. 27 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 27-1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas H. Albiker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma T. Kuhlke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Chas H. Albiker
(Address) 2509 E. Fayette St

15 Filed AUG 25 1920 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1920, to Aug 23, 1920, that I last saw him alive on Aug 23, 1920, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Diarrhoea Enteritis two 20 d.

(duration) — yrs. — mos. —

CONTRIBUTORY (Secondary) Tuberculosis

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Walter A Coe, M. D.

8-24, 1920 (Address) 371 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	aug 25 1920

20 UNDERTAKER F. B. Kepfinger ADDRESS 2216 Fulton ave

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L45997

HEALTH DEPARTMENT—CITY OF BALTIMORE

D45997

CERTIFICATE OF DEATH.

REGISTERED NO. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 Washington road ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David F. Hoff

(a) RESIDENCE. NO. 26 Washington Road Morrell Park WARD.
(Usual place of abode) (if nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6 - 1920

7 AGE	Years	Months	Days	if LESS than 1 day, hrs. or min.
		3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work \ no

(b) General nature of industry, business, or establishment in which employed (or employer) \

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm J. Hoff

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Blanche Burns

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Wm J. Hoff (Address) 16 Washington Road

15 Filed AUG 25 1920 CORNEY F. TRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1920

17 I HEREBY CERTIFY, That I attended deceased from August 14, 1920, to August 23, 1920, that I last saw him alive on August 23, 1920, and that death occurred, on the date stated above, at 10.20 P, m.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis.

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Inanition.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 25 Washington Rd.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Howard H. Warner M. D.

19 (Address) Robert Garrett Hosp. Dispensary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 25 1920
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 45998

1042 D 45998

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hosp ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Welch

(a) RESIDENCE. NO. 2303 E. Preston St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Richard Welch

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Kane

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Hospital Record
(Address)

15 Filed AUG 25 1920, 19.. ROBERT E. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 19 20, to Aug 23, 19 20, that I last saw h[illegible] alive on Aug 23, 19 20, and that death occurred, on the date stated above, at 12 00 M.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Patient's home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Aug 25 1920
20 UNDERTAKER Margaret S. Flynn	ADDRESS 1422 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. OCCUPATION should be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE

Spec.—5-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

845999 845999

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 Myrtle Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henrietta James

(Residence in Baltimore: No. 1209 Myrtle Ave St.; ..... yrs., 7 mos. 2 ds.)

WRITE PLAINLY; WITH UNFADING INK—THIS IS IMPORTANT.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Black	Widow

6-DATE OF BIRTH, Aug 20, 1835
(Month) (Day) (Year)

7-AGE, 85 yrs. ..... mos. 4 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles Pinkney

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ellen Parks Pinkney

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Wright

(Address) 1209 Myrtle Ave

15-

Filed AUG 25 1920, 191.....

ROBERT B. KRAUTER
Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 24, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8 1920, to Aug 24 1920, that I saw her alive on Aug 8 1920, and that death occurred, on the date stated above, at 3 9 m.

The CAUSE OF DEATH* was as follows:

.....

old age

..... (Duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Right hemiplegia

..... (Duration) ..... yrs. 7 mos. ..... ds.

(Signed) Geo. Bennewitz M. D.

Aug 24 1920 (Address) 600 Hanover Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loud County	August 26 1920
20-UNDERTAKER John H. Owens	ADDRESS 5-38 Dol

D46000

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 D46000

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital · St.: 5 Ward)

(If death occurred in a hospital or Institution, give Its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME John Cadney

(Residence in Baltimore: No. 1234 mc Elderry St.; yrs., — mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Col	Married

6-DATE OF BIRTH, July (Month) 4 (Day), 1871 (Year)

7-AGE, 49 yrs. 1 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): H&O

9-BIRTHPLACE. (State or Country), Va

PARENTS.

10-NAME OF FATHER, Jon Cadney

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Mary Joyce

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nettie Cadney

(Address) West Point Va

15- ROBERT F KRAUTER

AUG 25 1920

1920 ....., 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Sypholis ?

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. K. Manley M. D.
(Coroner.)

8-25, 1920 (Address) 3 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence West Point Va

19-PLACE OF BURIAL OR REMOVAL, West Point Va — DATE OF BURIAL, Aug 25, 1920

20-UNDERTAKER Thos Rolt & Elliott — ADDRESS 1725 Ashland Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

846001 + 402 846001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Rabbath

(a) RESIDENCE. NO. Westland Virginia ST., WARD. Westland Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 3 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 27-857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fisherman

(b) General nature of industr., business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Emil Rabbath

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margt Willey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record
(Address) J. H. H.

15 Filed AUG 25 1920 19 ... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1920, to Aug 23, 1920, that I last saw h.. alive on Aug 23, 1920, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Post Operative Shock.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach ?

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes No Date of Aug 21

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Monahan, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westland Va

DATE OF BURIAL: aug 25 1920

20 UNDERTAKER: Joseph Ahearn

ADDRESS: 221 W Bway

MARGIN MUST NOT BE WRITTEN IN OR CUT—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK

Spec.—8-24-14—M. & T.—2000 Bks.

D.46002

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46002

CERTIFICATE OF DEATH.

39 V

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5007 Fraser Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles B Hamburg

(Residence in Baltimore: No. 5007 Fraser Ave St.; 70 yrs., 1 mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CITY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Aug (Month) 30 (Day) 1838 (Year)

7-AGE, 81 yrs. 11 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Bernard Hamburg

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret Behlenberg

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Hamburg Jr.

(Address) 1716 E. Eliston St

15-

AUG 25 1920

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 23 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 1 1920, to Aug 23 1920, that I saw h[illegible] alive on Aug 1 1920, and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows:

Cancer, Tongue

(Duration) ....yrs. 11 mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs. 1 mos. ....ds.

(Signed) Geo H Hechinger M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Aug 26, 1920
20-UNDERTAKER	**ADDRESS**
William Cook	502 E. York Ave

Essex & Essex Sts. (Wojek)

D.46003

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46003

CERTIFICATE OF DEATH.

175-00

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. Essex St.; 1 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Wojek

(Residence in Baltimore: No. 7139 Cambridge St.; yrs., 5 mos., 1 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Examine statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Sept (Month) 8 (Day), 1913 (Year)

7-AGE. 6 yrs. 11 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wladyslaw Wojek

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Lucy Mozarek

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wladyslaw Wojek

(Address) 7139 Cambridge St.

15- Filed AUG 25 1920, 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 23 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest also (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Coroner also find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Crushed To Death by Automobile

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Thomas Gray Marshall M. D. (Coroner)

Aug 26, 1920 (Address) 1005 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL, OR REMOVAL, Holy Rood — DATE OF BURIAL, Aug 26 1920

20-UNDERTAKER Wm Hamilton — ADDRESS West

Spec.—8-24-14—M. & T.—2000 Bks.

D. 46004

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 46004

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1 2 3 N. 44 ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Collison

(Residence in Baltimore: No. 3 2 N. 44 St. St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Sept 26, 1913.
(Month) (Day) (Year)

7-AGE, ...yrs. 10 mos. 28 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Henry Collison

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Edna Chmowel

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Collison

(Address) Brooklyn Md

15-

Filed AUG 25 1920, 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 24., 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 13 1920, to Aug 24 1920, that I saw h.. alive on Aug 24 1920, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Whooping Cough

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas. W. Brown M. D.

Aug 25, 1920 (Address) Brooklyn Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	Aug 26, 1920
20-UNDERTAKER John F Denny	ADDRESS, 715 Light St

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS BLANK

Spec.—6-9-19—H. P. Co.—1000 Bka.

D.46005 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46005

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 E Biddle ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Shipley

(a) RESIDENCE. No. 607 E Biddle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H Shipley

6 DATE OF BIRTH (month, day, and year) Oct 13 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carrollton Md

PARENTS

10 NAME OF FATHER H. Stansbury

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah A Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant William H Shipley (Address) 607 E Biddle St

15 Filed AUG 25 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 23, 1920, to Aug 23, 1920, that I last saw h[illegible] alive on Aug 23, 1920, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 3 hrs

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 607 E Biddle St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

8/24 1920 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 26 1920
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

MARGIN RESERVED

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D. 46006

HEALTH DEPARTMENT--CITY OF BALTIMORE

D. 46006

CERTIFICATE OF DEATH

120

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2051 Gough St.: 2 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresa Kippner

(Residence in Baltimore: No. 2051 Gough st St.: 50 yrs. mos. ds.)

MARGIN MUST NOT BE WRITTEN IN—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: Feby 16, 1920 (Month) (Day) (Year)

7-AGE: 77 yrs. 6 mos. 5 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housework at
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: Got Known

11-BIRTHPLACE OF FATHER (State or country): "

12-MAIDEN NAME OF MOTHER: "

13-BIRTHPLACE OF MOTHER (State or country): "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Lena Graemick

(Address) 2051 Gough St

15.

AUG 25 1920 (Date) Robert P. Harrison, 191 .....

Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: August 24, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1920, to Aug 23 1920 that I saw her alive on Aug 23, 1920. and that death occurred, on the date stated above, at 8 45 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 2 yrs. ..... mos. ..... ds

Contributory (SECONDARY) Chronic Nephritis

Dr Lena Kopf

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Patterson M. D.

Aug 26, 1920. (Address) 508 E North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Cross Cemetery D.A., Co Md

DATE OF BURIAL: Aug 26, 1920

20-UNDERTAKER: John F Denny

ADDRESS: 715 Light st

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46007 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46007

CERTIFICATE OF DEATH. 1202

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 Ashburton St. ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Leonard McMorris

(a) RESIDENCE. NO. 1716 Ashburton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy M. McMorris

6 DATE OF BIRTH (month, day, and year) June 23-1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shirt Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Henry Myer Co.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Geo. R. McMorris

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Rachael Gills

13 BIRTHPLACE OF MOTHER (city or town) Harford Co.

(State or country) Md.

14 Informant Lucy M. McMorris

(Address) 1716 Ashburton St.

15 Filed AUG 25 1920 19.. Robert F. ... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25 1920

17 I HEREBY CERTIFY, That I attended deceased from July, 1904, to Aug. 25, 1920, that I last saw him alive on Aug 24, 1920, and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis

(duration) 16 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Balto. City

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine exam

(Signed) W. H. Smith, M. D.

Aug 25, 1920 (Address) 3429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	Aug. 27 1920
20 UNDERTAKER	ADDRESS
Horace Burgee & Son	363 Falls Rd.

1046008 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046008

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Near Arlington Station St.: 28 17 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Butcher

(Residence in Baltimore: No. Arlington (Main St), St.: 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	single

6-DATE OF BIRTH, August 27, 1863
(Month) (Day) (Year)

7-AGE, 56 yrs. 11 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Gardner
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, James W. Butcher

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Jane Snellings

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Sara L Briscoe

(Address) 709 6th St N.E. Wash D.C.

15- Filed AUG 26 1920, 191.... ROBERT E. LEAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured skull Caused by being struck by Westerns Manufacturing Pneumatic Tire Instant death (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .... (Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

August 26 1920 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL	DATE OF BURIAL, ..., 19....
Fredericksburg Va	Aug 28 20
20-UNDERTAKER	ADDRESS
A S Marshall	3539 Gay St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT...

Spec.—8-24-14—M. & T.—2000 Bks.

D46009

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46009

CERTIFICATE OF DEATH.

24

25

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 86 Annapolis Ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Helen Williams

(Residence in Baltimore: No. 86 Annapolis Ave not Veronica St.; ..... yrs., ... mos. ..... ds.)

WRITE PLAINLY; WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Infant

6-DATE OF BIRTH, ... Aug (Month) 18 (Day), 1920 (Year)

7-AGE, no yrs. no mos. 6 ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Ernest Williams

11-BIRTHPLACE OF FATHER (State or Country), Ark.

12-MAIDEN NAME OF MOTHER Jennie Espey

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Williams

(Address) 86 Annapolis

15-

Filed ....., 191..... ROBERT J. KRAUTER Registrar.

AUG 28 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 24 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 23 1920, to Aug 24 1920, that I saw her alive on Aug 23 1920, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

..... Tetanus

.....

.....

..... (Duration) no yrs. no mos. 2 ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Raymond Johnson M. D.

Aug 24, 1920 (Address) 1 Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Cella Cem	Aug 25, 1920
20-UNDERTAKER Daniel Easter	ADDRESS 916 Pa Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46010 D46010

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 Eastern Ave St.; 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn L. Roeseke

(a) RESIDENCE. NO. 2204 Eastern Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs 10 mos 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16 97

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John T. Roeseke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Augusta Bongart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) John T. Roeseke 2204 Eastern Ave

15 Date Received AUG 26 1920 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 14 1920 to Aug 23 1920

that I last saw her alive on 8 23 1920

and that death occurred, on the date stated above, at 5.55 P. m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C S Green, M. D.

19 (Address) 408 S Bathurst

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	Aug 26 1920
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Arlington Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE sh CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Blks.

D46011

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46011

CERTIFICATE OF DEATH.

1042

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 242 S. Collington ave.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Edward O'Donnell.

(a) RESIDENCE. No. 242 S. Collington Ave ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of child

6 DATE OF BIRTH (month, day, and year) Jan 3 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None Ent. 600

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph O'Donnell.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Crist

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Joseph O'Donnell.
(Address) 242. S Collington Ave

15 Filed AUG 26 1920 ROBERT P. BRADEN Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1920, to Aug 25, 1920, that I last saw h— alive on Aug 25, 1920, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. Wenker M. D.

(Address) 160 Bond Aug 25, 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug 27th 1920

20 UNDERTAKER John A. Moran ADDRESS 3000 E. Baltos

MARGIN RESERVED

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46012

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46012

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 N Duncan ST.: 6 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sofia Novotny,

(a) RESIDENCE. NO. 422 N Duncan ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Don't Know

6 DATE OF BIRTH (month, day, and year) Don't Know 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria.

PARENTS

10 NAME OF FATHER Don't Know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria.

14 Informant Miss Barbara Jendrick
(Address) 422 N Duncan

15 Filed AUG 26 1920 Burial Permit Issued

EDGAR S. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 5 1920, to Aug 24 1920

that I last saw her alive on Aug 24 1920

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) J. Mudgett, M. D.

Aug 25, 1920 (Address) 2008 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Aug 27 1920
20 UNDERTAKER J Herwig & Co	ADDRESS 2008 Madison

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

246013 ✓ 246013

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2233 Brookfield ST.: 13 WARD)

2-FULL NAME Henrietta Sachs

(a) RESIDENCE. No. 2233 Brookfield Ave ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 3-1863

7 AGE — Years: 57 — Months: 4 — Days: 22 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Philip Sachs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Fannie Levy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Ralph Sachs
(Address): 2233 Brookfield ave

15 Filed AUG 26 1920 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1920, to Aug 25, 1920, that I last saw h..... alive on ~~June~~ Aug 19, 1920, and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

..... (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas Adler, M. D.

, 19 (Address) 1900 Madison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chev Shalom Cem — DATE OF BURIAL: Aug. 27th 1920

20 UNDERTAKER: David Sondheim — ADDRESS: 118 S. Mt Royal Ave.

MARGIN RESERVED

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR RECORDING DATA

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 46014 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ + 170 D 46014

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wesley Steele

(a) RESIDENCE. NO. Westminster Md ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William R Steele

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Annie Bames.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mr Levin

(Address) Wesley Apts. City.

15 Filed AUG 26 1920, 19 ROBERT S [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 18, 1920, to Aug 26, 1920; that I last saw him alive on Aug 25th, 1920 and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Uremia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration Chronic Endocarditis (duration) yrs. 6 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of August 18th

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) John D Whitacre M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Cemetery	Aug 28 1920
20 UNDERTAKER	ADDRESS
H Bankard & Son	Westminster Md

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46015

D 46015

CERTIFICATE OF DEATH.

28

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 Poppleton ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph F. Garrigan

(Residence in Baltimore: No. 114 Poppleton St.; 25 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Jan. (Month) 23 (Day), 18.16 (Year)

7-AGE,	If LESS than 1 day,
44 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Policeman
(b) General nature of industry, business, or establishment in which employed (or employer): 061

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Peter Garrigan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary A. Carey

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph F. Garrigan

(Address) 114 N. Poppleton St

15-

Filed AUG 28 1920, 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1920, to Aug. 25 1920, that I saw him alive on Aug. 24 1920, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. 2 mos. ds.

(Signed) Robert C Blake M. D.

Aug. 25, 1920. (Address) 1014 W. Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
New Cathedral	Aug. 26, 1920
20-UNDERTAKER H. C. Manning & Son	ADDRESS 617 N. Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 46016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46016

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Olivier ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Dupiers

(a) RESIDENCE. No. 1704 Crystal Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1, 1920

7 AGE: Years 5 Months Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Wm J. Dupiers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Bertha Baldwin

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Wm J. Dupiers

(Address) 1704 Crystal Ave

15 Filed ..... 19 .....

AUG 25 1920 Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-25 1920

17 I HEREBY CERTIFY, That I attended deceased from July 24 1920 to Aug-25 1920 that I last saw h. alive on Aug. 25 1920, and that death occurred, on the date stated above, at 4-40 P. m.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Intestinal Intoxication

31 Dys (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) H. A. Murrina M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Aug 27 1920

20 UNDERTAKER: Robt F Turner Sons

ADDRESS: 1402 E Broadway

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1946017 + 104 1946017

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp (ST.:) 7 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Bolick

(a) RESIDENCE. No. Staunton Draft, Va ST., WARD. Staunton Draft Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 2 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
		5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Bolick

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Mary Coyner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Hospital Record

(Address) Johns Hopkins Hosp

15 AUG 26 1920

ROBERT B. BREUER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 20, 1920 to Aug 25, 1920

that I last saw him alive on Aug 25, 1920

and that death occurred, on the date stated above, at 1:45 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Diarrhea

(Signed) Harold L. Huggins, M. D.

8/26 1920 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Basic City Va.	Aug 26 1920
20 UNDERTAKER John F Denny	ADDRESS 715 Eighth

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1900 Blks.

D46018

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D46018

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 936 S. Bouldin ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Fechter

(a) RESIDENCE. No. 936 S. Bouldin ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 12. 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sawyer 042

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Duker Box Mnf'g Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER August C. Fechter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Schmattner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Isenhardt (Address) 936 S. Bouldin

15 Filed AUG 26 1920 ROBERT P. LEAUTIER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1920, to Aug 25, 1920, that I last saw him alive on Aug 24, 1920, and that death occurred, on the date stated above, at 9.35A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 5 mos. 18 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jas. L. Hooper, M. D.

8-26, 1920 (Address) 3462 E. 28 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz's Cemetery	Aug 27 1920
20 UNDERTAKER	ADDRESS
Zirkle & Zirkle	1739 E. Eager St

MARGIN RESERVED FOR BUREAU OF VITAL STATISTICS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

D46019 HEALTH DEPARTMENT—CITY OF BALTIMORE D46019

CERTIFICATE OF DEATH.

150

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1066 Shield's alley ST.: 1" WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marcella Scott

(Residence in Baltimore: No. 1066 Shields Alley St.; yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	single

6-DATE OF BIRTH, ... July (Month) 1, (Day) 1925 (Year)

7-AGE, ... yrs. 1 mos. 24 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Durham's Bd

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Moses Scott

11-BIRTHPLACE OF FATHER (State or Country), Massachusetts

12-MAIDEN NAME OF MOTHER Hattie Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. Scott

(Address) 1066 Shields alley

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... August 24 (Month) (Day), 1925 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Typhoid Fever Acute

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Intestinal Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

August 24 1925 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
W Laurens Lee	Aug 26 1925
20-UNDERTAKER	ADDRESS
David Earley	966 Pa Ave

IMPORTANT.—Physicians are requested to fill out all items, as much as may be practicable, and to write plainly. Any error or omission may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

046020

HEALTH DEPARTMENT—CITY OF BALTIMORE

046020

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. City Hospital, Bay View WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Pine.

(a) RESIDENCE. NO. ? ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General laborer

(b) General nature of industry, business, or establishment in which employed (or employer) — 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentucky.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Records.
(Address) City Hospital, Bay View

15 Filed AUG 26 1920, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 24, 1920.

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1920, to Aug. 24, 1920, that I last saw him alive on Aug. 24, 1920 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis (no cerebral hemorrhage or thrombosis)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann

(Signed) B. H. Orman, M. D.

, 19 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL AUG 26 1920, 19

20 UNDERTAKER Commissioner Health.

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

220

AUG 26 1920

Burial Permit Issued

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46021

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D46021

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1413 McCulloh ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Gassaway

(a) RESIDENCE. No. 1413 McCulloh ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (~~WIFE of~~) Ella Gassaway

6 DATE OF BIRTH (month, day, and year) Jan 2, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Porter

(c) Name of employer John E Hurst

9 BIRTHPLACE (city or town) (State or country) Howard Co Md.

PARENTS

10 NAME OF FATHER George Gassaway

11 BIRTHPLACE OF FATHER (city or town) Montgomery (State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel Chew

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant William Gassaway
(Address) 1413 McCulloh St

15 Filed AUG 26 1920 19 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1920

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1920, to Aug 25, 1920, that I last saw him alive on Aug 25, 1920, and that death occurred, on the date stated above, at 6-20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Muscular Rheumatism

(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. William Frey, M. D.

8pt. 1920 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Star Cemetery	Aug 27 1920
20 UNDERTAKER	ADDRESS
Edward P Lee	903 Edmondson Ave & Eaton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46022

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46022.

CERTIFICATE OF DEATH.

X 79 V

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St. Josephs Hospital ST.: 9 WARD)

2-FULL NAME Francis Muse

(a) RESIDENCE. No. Bangies (Balto. County) ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Muse

6 DATE OF BIRTH (month, day, and year) April 2 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bangies Md

PARENTS

10 NAME OF FATHER Frank Parks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Thomas Muse
(Address) Bangies Md

15 Filed AUG 26 1920 BURKET B ... Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 25 1920

17 I HEREBY CERTIFY, That I attended deceased from August 22, 1920, to August 25, 1920, that I last saw her alive on August 25, 1920, and that death occurred, on the date stated above, at 2.45 9 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocarditis.

(duration) 4 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? History, Physical Findings, Laboratory

(Signed) W. C. Deaderick M.D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bangies Md	Aug 29 1920
20 UNDERTAKER I L Gray & Son	ADDRESS 108 W Monty

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46023

HEALTH DEPARTMENT—CITY OF BALTIMORE

170 D46023

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1512 Riverside ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd G. Foard

(a) RESIDENCE. NO. 1512 Riverside ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Margaret Foard

6 DATE OF BIRTH (month, day, and year) 1839

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ships Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Margaret Foard (Address) 1512 Riverside Ave.

15 Filed AUG 26 1920 ROBERT B. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 13 1920, to Aug. 25th 1920, that I last saw him alive on Aug. 25th 1920, and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Chron Interstit. Nephritis

Long Standing (duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Roth. B. A. Schmidt, M. D.

, 19 (Address) 1315 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cem	7/27 19
20 UNDERTAKER	ADDRESS
Wm J. E. Evans	Govans Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 46024

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46024

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1721 Corrington St.; 24 WARD) 104

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna Bayard Eidman

(Residence in Baltimore: No. 1721 Corrington St. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... May ..... 23 ....., 1920
(Month) (Day) (Year)

7-AGE, ... yrs. 3 mos. 3 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry F. Eidman

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Edna Bruce

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Eidman

(Address) 1721 Corrington St.

15- AUG 26 1920 ROBERT B KRAUTER
Filed ..... 191.....
Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug. 25 ....., 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 10 1920, to Aug 25 1920, that I saw her alive on Aug 24 1920, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Acute Substernal Carcinoma

.....

.....

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. 16 ds.

(Signed) ..... M. D.

8/27/20, 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Aug 27., 1920

20-UNDERTAKER, E. J. Fanning & Son

ADDRESS 1460 Battery Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46025

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 Forest ST. 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E Hartman

(a) RESIDENCE. NO. 714 Forest ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Hartman.

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Costello

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret Hannan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Margaret Costello (Address) 714 Forest St

15 Filed AUG 28 1920 ROBERT B KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24 1920

17 I HEREBY CERTIFY, That I attended deceased from July 2 1920, to August 24 1920.

that I last saw her alive on August 23. 1920

and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy Bright's Disease

Contributory (duration) yrs. 7 mos. 5 ds.

(Secondary) Kidney & Heart Disease

(duration) yrs. 7 mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. J. Wennard, M. D.

8-24 1920 Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Aug 27 1920
20 UNDERTAKER	ADDRESS
E J Fanning & Son, 1938	E Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46026

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46026

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3008 Mc Ray Court ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda V Ludwig

(a) RESIDENCE. NO. 3008 Mc Ray Court WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 31-1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm G Ludwig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary V Kurtz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant James V Ludwig

(Address) 1930 E Monument

15 Filed AUG 26 1920, 19 Registrar

CHAS. B. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 20th, 19 20, to Aug 26th, 19 20,

that I last saw h alive on Aug 25th, 19 20,

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam of Sputum

(Signed) W. G. Schmidt M. D.

, 19 (Address) 727 Gilmore Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	July 29-1920

20 UNDERTAKER Wm Cadzow & Son ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46027

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46027

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1729 Harford ave

CITY OF BALTIMORE: (No. 1729 Harford ave ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ethel C. Gorsuch

(a) RESIDENCE. No. 1729 Harford ave ST., 8 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? ~~37~~ yrs ~~7~~ mos. ~~7~~ ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married,~~ Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles P. Gorsuch

6 DATE OF BIRTH (month, day, and year) Jan. 7 1883

7 AGE 37 Years	7 Months	7 Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Cornelius Frazier

11 BIRTHPLACE OF FATHER (city or town) Frederick (State or country) Frederick Co

12 MAIDEN NAME OF MOTHER Mary Herring

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Charles P. Gorsuch

(Address) 1729 Harford ave

15 Filed AUG 26 1920 ROBERT B. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 3 1919, to Aug 24, 1920 that I last saw her alive on Aug 24, 1920 and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A. W. Macdonald, M. D.

Aug 25 1920 Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	8/28 1920.

20 UNDERTAKER George J. Ruth ADDRESS 1235 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46028 + 53 D46028

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A. Kelly Hosp. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Wilhelmina Gibbons Cooper

(Residence in Baltimore: No. Howard A. Kelly Hospital St.; ..... yrs., ... mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) August (Day) 29, (Year) 1887

7-AGE, 33 yrs. 7 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Wilmington Del

9-BIRTHPLACE, (State or Country), Wilmington Del

PARENTS.

10-NAME OF FATHER, William Gibbons

11-BIRTHPLACE OF FATHER (State or Country), Penna Gibbons

12-MAIDEN NAME OF MOTHER Carolina Gibbons

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. G. Cooper

(Address) Oxford N. C

15. AUG 26 1920 ROBERT B KRAUTER

Filed ....., 191.... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... August (Month) 26 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 29 1920, to Aug. 26 1920, that I saw her alive on August 26 1920, and that death occurred, on the date stated above, at 1 OO p. m.

The CAUSE OF DEATH* was as follows:

Hodgkin's disease

(Duration) 4 yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robt E. Fricke M. D.

Aug. 26, 1920. (Address) 1418 Eutaw Place.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 28 ds. In the State ..... yrs. ..... mos. 28 ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Oxford, North Carolina

19-PLACE OF BURIAL OR REMOVAL, Oxford N. C. DATE OF BURIAL, Aug 29 1920

20-UNDERTAKER Chas. G. Black ADDRESS 742 W. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46029 HEALTH DEPARTMENT—CITY OF BALTIMORE D46029

CERTIFICATE OF DEATH.

REGISTERED NO. 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME James J. Shield.

(a) RESIDENCE. No. Burnham Pa ST., 28 WARD. (Burnham Pa)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 8 mos. 0 ds. How long in U. S., if of foreign birth? 44 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single -

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about - 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
44	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steel Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Steel mills Dbo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Burnham Pa

PARENTS

10 NAME OF FATHER Bernard Shields

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Langton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Md.

15 Filed AUG 26 1920 19 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26th 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 7th, 1920, to Aug 26th, 1920, that I last saw h alive on Aug 25th, 1920, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Paresis (Specify) -

To our knowledge abt (duration) yrs. 8 mos. 0 ds.

CONTRIBUTORY (Secondary) Mania Paretic - (duration) 0 yrs. 8 mos. 0 ds.

18 Where was disease contracted if not at place of death? Pa -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? W. Wass -

(Signed) Frank J Flannery M. D.

Aug 27, 1920 (Address) Frank J Flannery

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lewistown - Mifflin Co. Pa

DATE OF BURIAL Aug 27/ 1920

20 UNDERTAKER STUART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46030 HEALTH DEPARTMENT—CITY OF BALTIMORE D46030

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3808 Montgomery Ave ST.: 78 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Jane Travers

(a) RESIDENCE. No. 3808 Montgomery Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Thomas H Travers.

6 DATE OF BIRTH (month, day, and year): Oct 14th 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nothing

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Moses Mavy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Lonthinnon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Turner Travers. (Address) 3808 Montgomery ave

15 Filed AUG 27 1920 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 25th 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1920, to Aug 25th, 1920, that I last saw him alive on Aug 25th, 1920, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary): Duration

(duration) yrs. 3 mos. — ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Palpation

(Signed) A. C. Smith, M. D.

, 19 (Address) 4209 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harmed Ridge — DATE OF BURIAL: Aug 27 1920

20 UNDERTAKER: Isaac Lyford Baltimore — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D46031

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D46031

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1512 E Balto St. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia H Buttner

(Residence in Baltimore: No. 1512 E. Balto St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept 6, 1871, 1
(Month) (Day) (Year)

7-AGE, 45 yrs. 11 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, John J Beil

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Annie Sause

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul R. Buttner

(Address) 1512 E. Balto St.

15-

Filed....., 191.... G. H. Grese
Registrar.

AUG 27 1920

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an [illegible]
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said [illegible]
(Inquest, autopsy or inquiry.)
and that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] D.
(Coroner.)
8 26, 1920 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery — DATE OF BURIAL, Aug 29, 1920

20-UNDERTAKER H Vander & Son — ADDRESS 1710 Fleet St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PRINT WITH INDELIBLE INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Blks.

D46032

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46032

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1251 Sargeant St. ST.; 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel a Semmont

(a) RESIDENCE. NO. 1251 Sargeant ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Jessie M Semmont

6 DATE OF BIRTH (month, day, and year): May 31-1881

7 AGE — Years: 39 — Months: ~~1881 May~~ 2 — Days: ~~31~~ 25 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: Susquehanna Ice Co

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Samuel Semmont

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Emma Riddoes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Newark Del.

14 Informant (Address): Jessie M Semmont

15 Filed AUG 27 1920 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 25 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 4 1919 to Aug 25 1920, that I last saw h in alive on Aug 23 1920 and that death occurred, on the date stated above, at 10 15 a.m.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia following

If no Ulners following

Tetonus

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lung

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of abt July 6/20

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. J. Carroll M. D.

. 19 (Address) 1740 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	aug 28 1920
20 UNDERTAKER: William Cook	ADDRESS: 502 E. Hoffman ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46033

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46033

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1231 Hanbut. ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie E. Tiernan

(a) RESIDENCE. NO. 1231 Hanbut. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? yrs. 10 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 13 - 19

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Martin Tiernan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Agnes Mattingly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Mary's Co.

14 Informant Mr. Martin Tiernan
(Address) 1231 Hanbut.

15 Filed AUG 27 1920 . 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 24, 1920, to Aug 26, 1920, that I last saw h/r alive on Aug 26, 1920, and that death occurred, on the date stated above, at 10-P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. Campbell, M. D.

Aug 27 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Cathedral Cem	8/28 1920
20 UNDERTAKER	ADDRESS
J. Fus McCully	130 E. Fay

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D46034

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

.79 D 46034

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 6 Singer ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph C. Shaver

(Residence in Baltimore: No. 6 Singer ave St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Unknown ....., 1847
(Month) (Day) (Year)

7-AGE, 73 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Baker

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph C. Shaver

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Elizabeth Mollet

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. V. Shaver

(Address) 6 Singer ave

15-

Filed AUG 27 1920, 191 ..... G. H. Cree

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH ....., Aug 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) ...find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows: Valvular disease of heart

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Morrison M. D.

Aug 26 1920 (Address) 732 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
London Park Cem	Aug 28, 1920
20-UNDERTAKER	ADDRESS
Chas. E. Franck	802 Madison ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 46035

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46035

CERTIFICATE OF DEATH.

REGISTERED NO. 99

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Aged Home St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myer Ellowitch

(a) RESIDENCE. NO. 1630 Jefferson St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Leurs
(Address) 1411 E. Balto St.

15 Filed AUG 27 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1920, to Aug. 26, 1920, that I last saw him alive on Aug 26, 1920, and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Alf Barfin M. D.

8/26 1920 (Address) 210 Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	8/27 1920
20 UNDERTAKER	ADDRESS
Jack Leurs	1411 E Balto

IMPORTANT, WRITE UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46036

CERTIFICATE OF DEATH.

1920 D 46036

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2440 Woodbrook Ave ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Levy

(a) RESIDENCE. No. 2440 Woodbrook Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Levy

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Levy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dead —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Louis 1411 E Baltimore St

15 Filed AUG 27 1920 19 G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/26 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1920, to Aug 26, 1920, that I last saw him alive on Aug 26, 1920, and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) O S Lloyd M. D.

19 (Address) 2232 Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Lond	Aug 27th 1920
20 UNDERTAKER	ADDRESS
Levi Levi	1411 E Balto St

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D46037

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46037

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 139 S Clinton St. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine A. Harman,

(Residence in Baltimore: No. 139 S. Clinton St. yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Married

6-DATE OF BIRTH, Sept 17 (Month), 1856 (Day) (Year)

7-AGE, 64 yrs. 11 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Michael Ahern

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Johanah Mackey

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos M. Harrison

(Address) 139 S. Clinton St.

15-

Filed, AUG 27 1920, 191.....

G. H. Grese.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 26, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows: Traumatism. Fell down stairs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Wirt Dunlap M. D.
(Coroner)
....., 191... (Address) 4 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery | DATE OF BURIAL, Aug 30, 1920

20-UNDERTAKER John A Moran | ADDRESS 3000 E Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.— 1000 Bks.

D 46038

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46038

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 Belnord Ave. ST.: 6 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Brough

(a) RESIDENCE. No. 106 Belnord Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. J. Brough.

6 DATE OF BIRTH (month, day, and year) Oct 1. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69.	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) House wife do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Wm. Forsyth

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Rebecca Moffett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant John Brough (Address) 3207 E Harmount Ave

15 Filed , 19 G. H. Gross Registrar

AUG 27 1920

Dr Meyer 6 E Balto St.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 19 20

17

I HEREBY CERTIFY, That I attended deceased from Aug 24 19 20, to Aug 26 19 20.

that I last saw her alive on Aug 26 19 20.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Osteo - Sclerosis

(duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C H Meyer Jr. M. D.

8/27. 19 20 (Address) 1638 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Oct 28 1920
20 UNDERTAKER John A. Moran	ADDRESS 3000 E. Balto St.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46039 D46039

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hosp. St. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen King

(a) RESIDENCE. No. 915 Sterling St. St., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Mulatto

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2 - 1899

7 AGE 21 Years 2 Months 4 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Fla

PARENTS

10 NAME OF FATHER John Barfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fla

12 MAIDEN NAME OF MOTHER Florence Randolph

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fla

14 Informant Hospital Record
(Address) J. H. H.

15 Filed ..... 19 .....

AUG 27 1920 G. H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1920 to Aug 25, 1920, that I last saw her alive on Aug 25, 1920, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Subacute Appendicitis

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 21, 20

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) Leo Yeo Brady, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel — DATE OF BURIAL: Aug 29 1920

20 UNDERTAKER: John W Henderson — ADDRESS 1502 E Monument

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46040

CERTIFICATE OF DEATH.

D46040

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 Stockton St ST.; 15 WARD)

REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria Herbert

(Residence in Baltimore: No. 1309 Stockton St St.; 6 yrs., — mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	C	Married

6-DATE OF BIRTH, October 25, 1870
(Month) (Day) (Year)

7-AGE. 50 yrs. 10 mos. 0 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9-BIRTHPLACE, (State or Country), Calvert County Md

PARENTS.

10-NAME OF FATHER, Merdell Carlton

11-BIRTHPLACE OF FATHER (State or Country), Calvert County Md

12-MAIDEN NAME OF MOTHER Lizzie Boyd

13-BIRTHPLACE OF MOTHER (State or Country), Calvert County Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James D. Carlton

(Address) 1022 Mount St

15-

Filed ....., 191.... G. H. Gross Registrar.

AUG 27 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1920, to Aug 25 1920, that I saw her alive on Aug 19 — 1920, and that death occurred, on the date stated above, at 12 45 m.

The CAUSE OF DEATH* was as follows:

Heart dilatation

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) General dropsy

(Duration) 1 yrs. 2 mos. ds.

(Signed) John D. Kenny M. D.

Aug 25, 1920 (Address) 1425 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Aug 27, 1920

20-UNDERTAKER JAMES H. DENNIS — ADDRESS 1303 PRESTMAN ST

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46041 — 50 D 46041

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Park Ave. near Rose Ave. ST. Raglsburg WARD 7-6

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Plumer

(a) RESIDENCE. No. Park Ave. near Rose Ave. ST. Raglsburg WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Plumer

6 DATE OF BIRTH (month, day, and year) March 19th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Truck Farm

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Edward Plumer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Clara Rhode

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Plumer (Address) Raglsburg Md.

15 Filed AUG 27 1920 Registrar C. H. Greer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26th 1920

17

I HEREBY CERTIFY, That I attended deceased from July 8, 1920, to Aug 26, 1920,

that I last saw him alive on Aug 25, 1920,

and that death occurred, on the date stated above, at 10:45 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

Mitral Regurgitation of Heart.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert D. Webster M. D.

, 19 (Address) Belair Rd Belevue Sta.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Joseph's Cemetery	Aug 28 1920
20 UNDERTAKER	ADDRESS
Fredk Lissenden Sons	Baltimore Md.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 46042 HEALTH DEPARTMENT—CITY OF BALTIMORE Vol 1 D 46042

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Street Hospital 15 WARD) 175

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret E Cole

(Residence in Baltimore: No. 1407 N Mount St.) (yrs., 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, Dec 7, 1908
(Month) (Day) (Year)

7-AGE, 11 yrs. 9 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country), Balto City.

PARENTS.

10-NAME OF FATHER, Henry Cole

11-BIRTHPLACE OF FATHER (State or Country), Balto, City

12-MAIDEN NAME OF MOTHER Margaret Banks

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Cole

(Address) 1429 Bruce St

15-

Filed AUG 27 1920 191 G. H. Cross Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 23, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) had that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed Chest I
Abdomen
Auto Accident
(Duration) ..yrs..mos. Hour

CONTRIBUTORY (Secondary) Internal Hemorrhage
(Duration) ..yrs. mos. Hour

(Signed) James McKenton M. D.
(Coroner.)

Aug 24, 1920 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death? ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Pennsylvania Ave

Former or usual residence 1407 N Mount St

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn — DATE OF BURIAL, Aug 28 1920

20-UNDERTAKER Edw Ringgold — ADDRESS 463 Grey St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Vester

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46043

D46043

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 110 W. Fort Ave ST.; 23 WARD)

2-FULL NAME Kate Vester

(a) RESIDENCE. No. 15 W. Fort Ave ST., 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C. D. Vester

6 DATE OF BIRTH (month, day, and year) June - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	2	24	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Nothing @ home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Saml. Shuman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Winton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant C. D. Vester

(Address) 15 W. Fort Ave

15 Filed AUG 27 1920 ROBERT B. BRAUER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1920

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1920, to Aug 20, 1920, that I last saw h.. alive on Aug 25, 1920, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Nephritis Chronic

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. Harmon Carter M. D.

Aug 26 1920 (Address) 825 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lwn & Oliver Cem	Aug 28 1920
20 UNDERTAKER E. Schloman & Son	ADDRESS 1037 Hanover

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state name, nature and duration of morbid conditions, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D46044 Body at city morgue

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46044

CERTIFICATE OF DEATH.

157

REGISTERED No. C.....

PLACE OF DEATH

CITY OF BALTIMORE (No. 661 W Fayette St. ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm A. Smith

(Residence in Baltimore: No. 661 W Fayette St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Don't Know

6-DATE OF BIRTH, ... Don't Know / ..... (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
75 about yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Don't Know

PARENTS.

10-NAME OF FATHER, " "

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... None

(Address).....

15- AUG 27 1920 ROBERT E. BRAUTEN

Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... August (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Hanging

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Gouge M. D. (Coroner)

Aug 26, 1920 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
	Aug 27, 1920
20-UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND
Commissioner Health.

Spec.—8-24-14—M. & T.—2000 Bks.

1046045 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046045

CERTIFICATE OF DEATH. 39

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1910 Boone ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cyprus Mitchell Cartwright

(Residence in Baltimore: No. 1910 Boone ST St.; 56 yrs. 4 mos. ds.)

Sanitarium Baltimore

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	married

6-DATE OF BIRTH. March 22, 1864
(Month) (Day) (Year)

7-AGE. 56 yrs. 4 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Elec Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Newspaper Pub

9-BIRTHPLACE, (State or Country), Charles Co. Maryland.

PARENTS.

10-NAME OF FATHER, James Cartwright

11-BIRTHPLACE OF FATHER (State or Country), Charles Co. Md.

12-MAIDEN NAME OF MOTHER Emma R. Cartwright

13-BIRTHPLACE OF MOTHER (State or Country), Charles Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. Mitchell Cartwright

(Address) 1910 Boone St.

15- AUG 27 1920 BOYLE & ERVIN

Filed....., 191.... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1920, to Aug 25 1920, that I saw him alive on August 22nd 1920, and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage and General Carcinosis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage from Nose

(Duration) yrs. mos. ds.

(Signed) Chas O Brady M. D.

Aug 28, 1920 (Address) 5 E. Pleasant St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cathedral — DATE OF BURIAL, Aug 28, 1920

20-UNDERTAKER E. A. Woodfield Jr. — ADDRESS Greenmount Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046046

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046046

CERTIFICATE OF DEATH.

REGISTERED NO. 1206

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1832 N. Saratoga ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Dorothy Pastorius

(a) RESIDENCE. NO. 1832 N. Saratoga ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gustav Pastorius

6 DATE OF BIRTH (month, day, and year) Feby. 8-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm. Markegal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothy Wernicke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Depner, (Address) 1832 N. Saratoga St.

15 Filed AUG 27 1920 ROBERT E. SLATTERY Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Apr 4, 1920, to Aug 25, 1920, that I last saw her alive on Aug 24, 1920, and that death occurred, on the date stated above, at 4. 15 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial nephritis nephritis secondary to Arterio Sclerosis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema Lungs (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic & Clyde Extract

(Signed) John A. Thatha M. D.

Aug 27, 1920 (Address) 1219 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug 28-1920
20 UNDERTAKER	ADDRESS
S. S. Offutt, Sr.	1231 E. Fayette St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46047 HEALTH DEPARTMENT—CITY OF BALTIMORE D46047

CERTIFICATE OF DEATH. X74

1-PLACE OF DEATH Church Home Infy. REGISTERED NO.

CITY OF BALTIMORE: (NO. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Master John Meade

(a) RESIDENCE. NO. 1114 Barclay St. ST., WARD. Delaware City Del.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. 7/12 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 31-1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14 yrs.	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER John J. Meade

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Anna Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Luke J. Meade
(Address) 1114 Barclay St.

15 Filed AUG 27 1920 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27. 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 16. 1920, to Aug 27. 1920, that I last saw him alive on Aug 27. 1920, and that death occurred, on the date stated above, at 12 15 a.m.

The CAUSE OF DEATH* was as follows:

(Post operative hemorrhage
Subdural over motor area.
1B

Eight hours & 15 min
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 26. 1920

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Noble, M. D.

. 19 (Address) Church Home Infy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Delaware City Del	Aug 28 1920

20 UNDERTAKER	ADDRESS
H. C. Wiedefeld & Sons	Granite

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D46048 HEALTH DEPARTMENT—CITY OF BALTIMORE D46048

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1004 Granby St ST.: 3 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pascua Ferrari

(Residence in Baltimore: No. 1004 Granby St St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Female	White	Infant

6-DATE OF BIRTH, August, 1920.
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 5 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Michael Ferrari

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Raffaela Petrini

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Ferrari

(Address) 1004 Granby St

15- AUG 27 1920 ROBERT P. LAUTER

Filed ....., 191.... BURIAL PERMIT CLERK Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 27, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs. ....mos. ....ds.

(Signed) H. L. Sussman, M. D.
(Coroner)

8/27, 1920 (Address) 1500 N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? [redacted]

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Timothy's Cem	Aug. ....., 1920
20-UNDERTAKER	ADDRESS
Kendall Tippett & Son	37 Hanover St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46049

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46049

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 Overland Ave. ST.; 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Anna Goszka

(a) RESIDENCE. NO. 208 Overland Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 29 yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 15 1859

7 AGE: Years 53 Months ... Days 9 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): " "

(c) Name of employer: " "

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Michal Grembocki

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Walter Goszki 208 Overland Ave

AUG 28 1920 C. H. G... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 25 1920

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1920, to Aug 25, 1920; that I last saw h... alive on Aug 24, 1920; and that death occurred, on the date stated above, at 1.10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ... yrs. 2 mos. 6 ds.

CONTRIBUTORY (Secondary): Chronic Valvular Heart Dis

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) W. J. Rysanek M. D.

(Address) Aug 28 20 1884 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Aug. 30 1920

20 UNDERTAKER: William Fiallowski — ADDRESS: 1... Caster

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
s on back of certificates. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46050

CERTIFICATE OF DEATH.

3/2 46050

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Shelton,

(a) RESIDENCE. No. 238 Colvin Str. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Black	Single.

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of)

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): North Carolina.

PARENTS

10 NAME OF FATHER: Sylvester Shelton.

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina.

12 MAIDEN NAME OF MOTHER: Emma ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina.

14 Informant: Hospital Records. (Address) City Hospital, Bay View.

15 Filed AUG 28 1920 G. H. Crese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26, 1920.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 3, 1920, to Aug. 26, 1920, that I last saw h alive on Aug. 28, 1920, and that death occurred, on the date stated above, at 2 00 P. m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency.
Myocardial insufficiency.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Syphilis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Wassermann.

(Signed) [illegible] M. D.

, 19 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel city	Aug 29 1920
20 UNDERTAKER: Mrs Robt a elholl	ADDRESS: 725 Eastland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D46051 HEALTH DEPARTMENT--CITY OF BALTIMORE D46051

CERTIFICATE OF DEATH

37

5

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 1411 May St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 16.)

2 FULL NAME Myrtle Bayley

(Residence in Baltimore: No. 1411 May St St.: Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word): Single

6 DATE OF BIRTH: October 30, 1914 (Month) (Day) (Year)

7 AGE: 5 yrs. 9 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Lawson Bayley

11 BIRTHPLACE OF FATHER (State or country): Talbot Co Md

12 MAIDEN NAME OF MOTHER: Sarah J Joshua

13 BIRTHPLACE OF MOTHER (State or country): Talbot Co Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah J Bayley

(Address) 1411 May St

15 AUG 28 1920 Filed . 191 G. H. Grace. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: August 26, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from August 20. 1920. to. August 26 1920. that I saw h alive on August 20. 1920. and that death occurred, on the date stated above, at 9 a m. The CAUSE OF DEATH* was as follows:

Hereditary Syphilis

(Duration) yrs. 1 mos. 20 ds.

Contributory (SECONDARY) Exhaustion

(Duration) yrs. mos. 7 ds.

(Signed). P E Jelly M. D.

Aug 27 1920 (Address) 300 E Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Laurel Cem DATE OF BURIAL: Aug 28 20

20 UNDERTAKER: Samuel Hemsley ADDRESS: 578 W Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D46052

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46052

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3401 Greymoak St. 28 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arnold M Ommen

(Residence in Baltimore: No. 3401 Greymoak St.: 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	married

6-DATE OF BIRTH. Sept. (Month) 13 (Day), 1852 (Year)

7-AGE. 67 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Pharmacist
(b) General nature of industry, business, or establishment in which employed (or employer): 025

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. John Ommen

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Christina Benger

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J John G Ommen

(Address) Fairmont & Potomac

15-

Filed AUG 28 1920, 191... G. H. Gross Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 25 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1920, to Aug 25 1920, that I saw him alive on Aug 25 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 20 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Harry S Beal M. D.

Aug 26, 1920 (Address) 20 E Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Aug. 28., 1920
20-UNDERTAKER	ADDRESS
J D Mitchell	1201 W Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46053 HEALTH DEPARTMENT—CITY OF BALTIMORE D46053

54

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Bay View Hospital ST.: 26 WARD)

2-FULL NAME Harriett Harley

(a) RESIDENCE. No. Bay View Asylum. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wm Harley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia,

12 MAIDEN NAME OF MOTHER Matilda Harley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Hospital Records.
(Address) City Hospital, Bay View

15 Filed AUG 28 1920 G. H. Gregg Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1920, to Aug. 25, 1920, that I last saw her alive on Aug. 25, 1920, and that death occurred, on the date stated above, at 10 30 A.m.

The CAUSE OF DEATH* was as follows:

Pernicious anemia.

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed) [illegible] M. D.

, 19 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem	8/28 1920
20 UNDERTAKER	ADDRESS
Chas F. Evans & Son	1130 W. Mt Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46054

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46054

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH Church Home + Infirmary. REGISTERED NO.....

CITY OF BALTIMORE: (No. 36 N. Broadway ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Sarah O'Brien

(a) RESIDENCE. No. 2722 E. Madison ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., If of foreign birth? yrs. mos ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed (write the word)
Female	White	Single.

5a If married, widowed, or divoreed
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 23 - 1903

7 AGE Years	Months	Days	If LESS than 1 day. hrs. or min.
17	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto Bargain House

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Patrick O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah J. O'Boyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Sarah J. O'Brien
(Address) 2722 E. Madison St.

15 Filed AUG 28 1920 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 24, 1920, to Aug 27, 1920; that I last saw h e alive on Aug 27, 1920, and that death occurred, on the date stated above, at 11 20 a.m.

The CAUSE OF DEATH* was as follows:

Extraluminic Goitre.

(duration) yrs. 4 mos. 20 ds.

CONTRIBUTORY (Secondary) Hemorrhage during operation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 27 1920

Was there an autopsy? No.

What test confirmed diagnosis? Surgical Exploration.

(Signed) Richard S Collins, M. D

Aug 27, 1920 (Address) Church Home + Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Aug 30 1920

20 UNDERTAKER Chas F. Evans & Son ADDRESS 1181 W. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should sign

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46055 D46055

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hilldon Heights ST.; 24th WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Wollenshade

(Residence in Baltimore: No. Hilldon Hghts. Woodlawn P.O. (If not in Baltimore give length of residence in yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH. June 15, 1843 (Month) (Day) (Year)

7-AGE. 77 yrs. 2 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Engineer 031
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lawrence J. Wollenshade

(Address) Windsor Mill Road

15- AUG 28 1920 Filed....., 191.... G. H. Cresse. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 27th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 10th 1920, to Aug 27th 1920, that I saw him alive on Aug 27th 1920, and that death occurred, on the date stated above, at 3.50 A. m.

The CAUSE OF DEATH* was as follows:

Valve Heart Trouble

Thickening of Valves

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

Chronic (Duration) 10 yrs. mos. ds.

(Signed) Thos. J. Everhart M. D.

Aug 27th, 1920 (Address) Woodlawn Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Mary's (Hampden) City — DATE OF BURIAL, Aug. 30., 1920

20-UNDERTAKER Henry Lutz — ADDRESS 1007 N. Bond St.

Physician will please write plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D46056

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46056

CERTIFICATE OF DEATH.

120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 251 E. Broadway ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Albert

(Residence in Baltimore: No. 251 E. Broadway St.; life yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-SINGLE, ~~MARRIED~~, WIDOWED, OR DIVORCED. (Write the word) Single

6-DATE OF BIRTH, Feb 26 (Month) (Day), 1874 (Year)

7-AGE, 46 yrs. 7 mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Locksmith
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. George Albert

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Margrt Wells

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Albert

(Address) 251 E Broadway

15- AUG 28 1920

Filed....., 191.... G. H. Grese Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 26 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 9 1920, to Aug 26 1920, that I saw h— alive on Aug 26 1920, and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows: over

Acute Nephritis

(Coma)

(Duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Influenza - (Acute Rheumatism)

(Duration) yrs. mos. 4 ds.

(Signed) [illegible] M. D.

Aug 27, 191... (Address) 135 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Schwarz Cemetery — DATE OF BURIAL, Aug 28, 1920

20-UNDERTAKER Johannah Candes — ADDRESS 946 Ausquith st

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Bowen

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46057

D 46057

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 N. Fulton Av ST.: 16 WARD)

2-FULL NAME: Mary A. Bowen

(a) RESIDENCE. NO. 824 N. Fulton Av ST., 16 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Bessie M. Bowen

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
39	2	12	

8 OCCUPATION OF DECEASED 089

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer) Lucas Drug Store

(c) Name of employer Cobley Balto. Md

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm D. Bowen

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or country)

12 MAIDEN NAME OF MOTHER Helen Ralph

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md (State or country)

14 Informant Bessie M. Bowen

(Address) 824 N. Fulton

15 Filed AUG 28 1920, 19 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8.27. 1920

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1920, to date of death, that I last saw h[illegible] alive on Aug. 27. 1920, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

The result of Pulmonary Tuberculosis by Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas. Lee Davis, M. D.

, 19 (Address) 824 N. Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug 30 1920
20 UNDERTAKER Graham F. Walker	ADDRESS 723 W Lafayette Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46058

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46058

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hosp. (St.:) 16 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Frey

(a) RESIDENCE. No. 1034 Stockton St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 5 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Frey

6 DATE OF BIRTH (month, day, and year) March 7, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Edward Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Cora Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) Kate Harris 1034 Stockton St

15 Filed AUG 28 1920 G. H. Cross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 17, 1920, to Aug 26, 1920, that I last saw h i alive on Aug 26, 1920, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis - Arterio Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Inter. Nephr.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emma E. Ridgely, M. D.

8/26 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill Cemetery Towson	Aug 29 1920
20 UNDERTAKER Mrs Roberta Allen	ADDRESS 725 Asland

1 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 46059

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46059

CERTIFICATE OF DEATH.

110

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 305 E. North Ave. ST.: 12 WARD)

2-FULL NAME Mary Barbra Blessing

(a) RESIDENCE. No. 305 E. North Ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7 - 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
48	40	7	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home wife 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Benjamin Meule

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Carol Pue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant H. Blessing
(Address) 305 E. North Ave

15 Filed AUG 28 1920 19 G. H. Gross. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1920

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1920, to Aug 27, 1920, that I last saw h e alive on Aug 26, 1920, and that death occurred, on the date stated above, at 2:15 a.m.

The CAUSE OF DEATH* was as follows:

General Peritonitis.

(duration) yrs. 3 mos. 29 ds.

CONTRIBUTORY (Secondary) Fecal Fistula.

Appendicitis + Septic Abt (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? Yes. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical + Examination

(Signed) Richard G. Coblentz, M. D.

8/27, 1920 (Address) Church Home + Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 28 1920

20 UNDERTAKER	ADDRESS
Robt. G. Turner	1422 E. Broadway

D46060

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 D46060

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 517 Poplar Grove ST.: 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Frances M. Haus

(Residence in Baltimore: No. 517 Poplar Grove St.: 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: July 17, 1895, 1 (Month) (Day) (Year)

7 AGE: 25 yrs. 1 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9 BIRTHPLACE (State or country): Bridgeport Conn

PARENTS

10 NAME OF FATHER: Frederick E Haus

11 BIRTHPLACE OF FATHER (State or country): Trumbull Conn

12 MAIDEN NAME OF MOTHER: Minnie E McGee

13 BIRTHPLACE OF MOTHER (State or country): Canada

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George L McGee

(Address) 517 Poplar Grove

15 Filed AUG 28 1920, 191 C. H. Grese REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug 27, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April, 1920, to, Aug 27 1920, that I saw h[illegible] alive on Aug 27, 1920, and that death occurred, on the date stated above, at 11.05 P m. The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(Duration) yrs. mos. 11 ds

Contributory (SECONDARY) Carcinoma Liver

(Duration) yrs. 4 mos. ds.

(Signed) H. Caspari M. D.

Aug 28, 1920 (Address) 1103 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Bradford Conn

DATE OF BURIAL: Aug 28, 1920

20 UNDERTAKER: John F Denny

ADDRESS: 715 Light

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46061 D 46061 X 120 D 46061

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 251 W. Hoffman ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin F. Henry

(a) RESIDENCE. NO. 251 W. Hoffman ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 4 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	—	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer 1857

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER John Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Margaret Bare

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Clarence B Henry

(Address) Chambersburg, Pa.

15 Filed AUG 28 1920 19.... G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27th, 1920

17

I HEREBY CERTIFY, That I attended deceased from July 22, 1920, to Aug 27, 1920, that I last saw him alive on Aug 27, 1920, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatis Nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pettigrain, M. D.

, 19 (Address) 817 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chambersburg, Pa.	Aug. 29 19 20
20 UNDERTAKER	ADDRESS
E & B Harle	115 E West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-46062

HEALTH DEPARTMENT—CITY OF BALTIMORE

150 D-46062

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 S. Castle St ST.: 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Davis

(a) RESIDENCE. NO. 713 S. Castle ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 27-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (0)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William F. Davis.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Marie Hovy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant William F. Davis

(Address) 713 S. Castle St.

15 Filed AUG 28 1920 Reg. G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1920, to Aug 27, 1920, that I last saw her alive on Aug 27, 1920, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation
(Foetus 7 lb 2 ozs)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY —
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B P Herzog M.D. M. D.

Aug 28. 1920 (Address) 1305 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	Aug 28 1920
20 UNDERTAKER Tilly & Zeiler	ADDRESS 403 S. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

946063

HEALTH DEPARTMENT—CITY OF BALTIMORE

1520 946063

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 234 Poplar St., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lennard Taylor

(a) RESIDENCE. No. 234 Poplar ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 25 98

7 AGE: Years — Months — Days: 2 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Bernard Hennisley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Edwina A Talbot

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Ella L Taylor

(Address) 2340 Gilmore St

15 Filed AUG 28 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1920, to Aug 27, 1920, that I last saw h[illegible] alive on Aug 27, 1920, and that death occurred, on the date stated above, at 7 1/2 P m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Atelectasis

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Edw. P. Fitzgerald M. D.

(Address) 1118 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Aug 28 1920
20 UNDERTAKER	ADDRESS
Daniel Easter & Co	916

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D46064 HEALTH DEPARTMENT—CITY OF BALTIMORE D46064

92

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 W. Hull ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah J. Lee

(Residence in Baltimore: No. 229 W Hull St.; 1 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH. ....., 1871
(Month) (Day) (Year)

7-AGE. 49 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer)..... 500

9-BIRTHPLACE, (State or Country) Cambridge. Md.

PARENTS.

10-NAME OF FATHER, John Wilson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Selena Mason

(Address) 229 W. Hull St

15- AUG 28 1920 G. H. Gross

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH ..... August 27, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1920, to Aug 27 1920, that I saw h[illegible] alive on Aug 26 1920, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) As Pneumonia

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) C. H. Fooks M. D.

Aug 28, 1920 (Address) 712 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cambridge. Md — DATE OF BURIAL, Aug. 29 1920

20-UNDERTAKER John H. Fooks — ADDRESS 143 W. Hull St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D46065 HEALTH DEPARTMENT—CITY OF BALTIMORE D46065

CERTIFICATE OF DEATH. X 172

1-PLACE OF DEATH REGISTERED No. C.....

CITY OF BALTIMORE: (No. U.S.P.H.S. Hospital #56, ST.: 24 WARD)

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lionel Woodruff,

(Residence in Baltimore: No. U.S.P.H.S. Hospital #56, Balto. Md. St.: ....yrs., ...mos. ....ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Unknown (Month), 1 (Day), ... (Year)

7-AGE, 22 yrs. ... mos. ... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seaman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E.T. Rembrandt Registrar

(Address) U.S.P.H.S. #56, Ft McHenry

15- AUG 28, 1920 G. H. Cross

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 26, 1920 (Month) (Day) (Year) 191..

17- I HEREBY CERTIFY, That I attended deceased from August 25 1920, to August 26 1920 that I saw him alive on August 26, 1920 and that death occurred, on the date stated above, at 2:45 m

The CAUSE OF DEATH* was as follows:

Rupture of spleen. Fracture of femur (bilateral). Fracture about ankle joint. Fracture about wrist joint.

(Accidental Fall) JHV

(Duration) ....yrs. ....mos. ....d

CONTRIBUTORY (Secondary) over

(Duration) ....yrs. ....mos. ....d

(Signed) J D Rembrand M.

Aug 26, 1920 (Address) Fort McHenry Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. X mos. 2 ds. In the State Md yrs. X mos. 2 ds.

Where was disease contracted if not at place of death? British Steamship Adre

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cemetery — DATE OF BURIAL, Aug. 28, 1920

20-UNDERTAKER Robt. F. Turner Jr. — ADDRESS 1442 N. Broadway

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46066 — 104 46066

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 764 W. Hamburg ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Lucille Duval

(a) RESIDENCE. NO. 764 W. Hamburg ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 5 1920

7 AGE — Years: — Months: 6 — Days: 22 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Warner J. Duval

11 BIRTHPLACE OF FATHER (city or town) (State or country): Elkton Md

12 MAIDEN NAME OF MOTHER: Pearl L. Sechrist

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Taylorsville Carroll Co. Md.

14 Informant (Address): Mrs. 764 W. Hamburg St.

15 Filed AUG 2, 1920 — ROBERT E. LAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1920, to Aug 26, 1920, that I last saw her alive on Aug 25 1920, and that death occurred, on the date stated above, at 8 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Cholera infantum

(duration) mos. 15 ds.

CONTRIBUTORY (Secondary) Malnutrition (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical

(Signed) M. C. Linginger M. D.

Aug 28 1920 (Address) 682 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cemetery

DATE OF BURIAL: Aug 28 1920

20 UNDERTAKER: James Dignan & Son

ADDRESS: 10 W. Saratoga St.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D46067 ✓ D46067

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital St., 19 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Murphy

(a) RESIDENCE. No. 521 Gilmor St. St., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Murphy

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Benj. Coates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Castina Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M.T.H.

15 Filed AUG 29 1920 ROBERT I. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 17, 1920, to Aug. 26, 1920, that I last saw her alive on Aug. 26, 1920, and that death occurred, on the date stated above, at 9.10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum

(Signed) L. Meigey. M. D.

8-27 1920 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
West Rivers Act Co	Aug 29 1920
20 UNDERTAKER	ADDRESS
James H Dennis	1303 Brentwood St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Body at 608 Vincent Av.

D46068

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46068

CERTIFICATE OF DEATH.

91

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 632 Bruce ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elsie Edwards

(Residence in Baltimore: No. 632 Bruce St.; yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	single

6-DATE OF BIRTH, May 25, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none (Duplex)
(b) General nature of industry, business, or establishment in which employed (or employer)..... 100

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Leo Edwards

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Leever Clayborn

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leever Clayborn

(Address) 608 Vincent Av.

15- AUG 29 1920

Filed....., 191.....

ROBERT J. KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest~~ inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ~~inquest~~ inquiry
(Inquest, autopsy or inquiry.)
find that said deceased came to ~~his~~ death on the day stated above.
The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration)..... yrs..... mos. 5 ds.

CONTRIBUTORY (Secondary) No History

(Duration)..... yrs..... mos..... ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)

Aug 26 1920 (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ... 19....
20-UNDERTAKER	ADDRESS AUG 27 192

JOHNS HOPKINS HOSPITAL

Commissioner of Health

Burial Permit

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D46069 D46069

47-091

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 N. Bond ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leander Thompson

(Residence in Baltimore: No. 523 N. Bond St.; ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Sing[le]

6-DATE OF BIRTH, December 3 1919
(Month) (Day) (Year)

7-AGE, ...yrs. 9 mos. ...ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Boy
(b) General nature of industry, business, or establishment in which employed (or employer): Boy

9-BIRTHPLACE, (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Edward Thompson

11-BIRTHPLACE OF FATHER (State or Country), St Mary's Co, Md

12-MAIDEN NAME OF MOTHER Emma Milburn

13-BIRTHPLACE OF MOTHER (State or Country), St Mary's Co, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Thompson

(Address) 523 N. Bond St

15- AUG 29 1920 Filed ... LOWERY B. KRAUTER ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 27 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 30/7/1920, to 27/8/1920, that I saw him alive on 26/8/1920, and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia, acute
Rheumatism, acute
Endocarditis, acute

(Duration) ... yrs. ... mos. 1 ... ds.

CONTRIBUTORY (Secondary) Exhaustion, ac.

(Duration) ... yrs. ... mos. [illegible] ds.

(Signed) Elmayfield Bass M. D.

27/8, 1920 (Address) 425 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	Aug 29 1920
20-UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D46070 D46070 150 D46070

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2025 E Lombard ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Follmeyer.

(a) RESIDENCE. NO. 2025 E. Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years — Months — Days — If LESS than 1 day, 7 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michael Follmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Cathrine Lewinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Michael Follmeyer

(Address) 2025 E. Lombard St

15 Filed AUG 29 1920 ROBERT B. LEAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1920, to Aug 28, 1920, that I last saw h im alive on Aug 28, 1920, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Debility

Foramen Ovale not closed

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. L. Fair, M. D.

Aug. 1920 (Address) 12 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus.

DATE OF BURIAL: Aug 29- 1920

20 UNDERTAKER: W. F. Sadowski.

ADDRESS: 905 S. Am

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46071

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46071

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 Ridgely ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul E. Riemann

(a) RESIDENCE. NO. 1105 Ridgely ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Frank Riemann

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Adams

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Frank Riemann
(Address) 1105 Ridgely st

15 Filed AUG 29 1920 19 ROBERT J. BRADY Registrar

BY [illegible] Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1920

17

I HEREBY CERTIFY, That I attended deceased from aug 14, 19 20, to aug 28, 19 20,
that I last saw h[illegible] alive on aug 27, 19 20,
and that death occurred, on the date stated above, at 7 - m.
The CAUSE OF DEATH* was as follows:

Broken Neck fracture

(duration) ....yrs., ...mos. 14 ds.

CONTRIBUTORY
(Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd, M. D.
28 F. 19 (Address) 62 Adams Ln

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Aug 30th 1920
20 UNDERTAKER	ADDRESS
E Schlosman & Son	Hanover st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D46072

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D46072

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 6105 Reedy ave St. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sara J Berry

(Residence in Baltimore: No. 6105 Reedy ave St.: 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, white | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept 3, 1845
(Month) (Day) (Year)

7-AGE. 74 yrs. 11 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 039

9-BIRTHPLACE, (State or Country), Hanover co - Md

PARENTS.

10-NAME OF FATHER, Jones Whitehead

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Maria Ramsey

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A. Berry

(Address) 6105 Reedy ave

15- AUG 29 1920 Forwarded
Filed....., 191.... BURIAL PERMIT Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 24, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia,

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY.....
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) J. Kent Sutton M. D.
(Coroner)
8-28-, 1920 (Address) 425 Cath.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Balto. Cem. | DATE OF BURIAL, Aug 28, 1920

20-UNDERTAKER John Burns Son | ADDRESS Towson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

1046073

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046073

X 108

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md General Hosp. (ST.:) 11 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel Knickerman.

(a) RESIDENCE. NO. Maryland General Hosp. WARD. Ellicott City

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 23, 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Knickman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Bertha Espey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Charles Knickman
(Address) Ellicott City Md.

15 Filed AUG 29 1920 ... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 28, 1920, to Aug. 28, 1920,

that I last saw her alive on Aug. 28, 1920,

and that death occurred, on the date stated above, at 10.15 P m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix with General Peritonitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/28/20

Was there an autopsy? no

What less confirmed diagnosis? Operative

(Signed) E. S. Coster, M. D.

8/28, 1920 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oella M.E. Cem. Balto. Co.

DATE OF BURIAL: Aug 31 1920

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

CAUSE OF DEATH in plain terms, so that it may be properly classified. Examination of BODY. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D46074

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D46074

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 327 Fauthill Ave ST.; 20 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patti Rhodes

(Residence in Baltimore: No. 327 Fauthill ave St.; 24 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOW(ER), OR DIVORCED, (Write the word.)
Female	colute	Widow

6-DATE OF BIRTH, Unknown m., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
45 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, David Bowen

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Rebecka Porter

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Mentzing

(Address) 327 Fonthill Ave.

15-

Filed AUG 29 1920, 191.....

ROBERT B. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 28, 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14 1920, to Aug 28 1920, that I saw her alive on Aug 27 1920, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis, Pneumonia Septicemia,

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Disease

(Duration) 4 yrs. ..... mos. 2 ds.

(Signed) Robert C Hetrick M. D.

Aug 28, 1920 (Address) 2157 Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cemetery	Aug 30, 1920
20-UNDERTAKER C. W. Dill	ADDRESS 3199 Frederick Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bka.

1046075

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046075

CERTIFICATE OF DEATH.

REGISTERED NO. 27 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5713 York Road ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gretta M. Heagle

(a) RESIDENCE. NO. 5713 York Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles M. Heagle

6 DATE OF BIRTH (month, day, and year): July 16 1898

7 AGE — Years: 22 — Months: 1 — Days: 11 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles N. McGinnis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Co

12 MAIDEN NAME OF MOTHER: Alice V. Hatten

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Charles M. Heagle 5713 York Road

15 Filed AUG 29 1920, 19 ROBERT A. LEAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 26, 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1920, to Aug. 26, 1920, that I last saw h... alive on Aug. 26, 1920, and that death occurred, on the date stated above, at 4 20 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about 1 year.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

... autopsy? No

What test confirmed diagnosis?

(Signed) Theodore N. Morrison M. D.

19 (Address) 101 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cem — DATE OF BURIAL: Aug 30 1920

20 UNDERTAKER: Jos Joerden & Son — ADDRESS: 217 S. Bro

CAUSE OF DEATH to be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46076

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46076

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1922 Pennsylvania Ave ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry M. Schoeffner

(a) RESIDENCE. No. 1922 Pennsylvania Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lizzie Schoeffner

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber 103

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Schoeffner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Nagel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lizzie Schoeffner
(Address) 1922 Pennsylvania Ave.

15 Filed AUG 29 1920 19 ROBERT A. LEAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 27, 1920

17 I HEREBY CERTIFY, That I attended deceased from August 22 1920. to August 27. 1920. that I last saw him alive on August 27. 1920. and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J. D. Hennessy, M. D.

, 19 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 30 1920

20 UNDERTAKER Jos Joerdens Son ADDRESS 2178 Pa

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46077

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46077

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Debus

(a) RESIDENCE. NO. Pleasant Hill Md. ST., WARD Pleasant Hill Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William H Debus

6 DATE OF BIRTH (month, day, and year): July 9 1861

7 AGE: Years 59 Months — Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto co md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Charles Debus

(Address): Washington md

15 Filed AUG 29 1920 ROBERT F. BRAUER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 27 1920

17 I HEREBY CERTIFY, That I attended deceased from August 26. 1920. to August 27. 1920. that I last saw h[illegible] alive on August 27. 1920. and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Strangulated Umbilical Hernia.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Toxemia from retention of intestinal contents (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At residence

Did an operation precede death? Yes No. Date of Aug. 26 1920

Was there an autopsy?

What test confirmed diagnosis? Physical Exam + Operation

(Signed) C. Gilbert Stewart M. D.

8/27. 1920 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasant Hill Cemetery

DATE OF BURIAL: aug 29 1920

20 UNDERTAKER: J. F. Elvis

ADDRESS: Reisterstown

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L046078 ✓ L046078

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 439 W Conway St. 22 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. Hicks jr

(a) RESIDENCE. No. 439 W Conway St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 8/3/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 800

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Hicks Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Gertrude Cornish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Gertrude Hicks

(Address) 439 W Conway

15 AUG 29 1920 19 ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/28/1920

17 I HEREBY CERTIFY, That I attended deceased from 8/26/20, to 8/28/20, that I last saw him alive on 8/28/20, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Inanition Prem. Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Guy Bowley, M. D.

8/29/1920 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 29 1920

20 UNDERTAKER Chas Geo H Hoffer ADDRESS 406 W Conway St

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D46079

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46079

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 632 W. Mulberry St.; 17 WARD)

REGISTERED NO. C 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Salvatore Saia

(Residence in Baltimore: No. 632 W. Mulberry St.; 25 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov 7, 1865
(Month) (Day) (Year)

7-AGE, 54 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Fruit Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) 043

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Antonio Saia

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Geppie

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carmela Saia

(Address) 632 W. Mulberry

15- AUG 29 1920 MOTHER'S [illegible]

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 28, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 9 1920, to Aug 28 1920, that I saw h[illegible] alive on Aug 28 1920, and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Luigi S. DeStefano M. D.

Aug 28, 1920 (Address) 407 N. Exeter St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Aug. 30. 1920

20-UNDERTAKER W. M. Routson — ADDRESS 230 N. Greene

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046080

1046080

CERTIFICATE OF DEATH.

104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 Hollins St. ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doris M. Kennedy.

(Residence in Baltimore: No. 1003 Hollins St. St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, May 5, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), 1003 Hollins St

PARENTS.

10-NAME OF FATHER, William O'Kennedy

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Dora A. Beck

13-BIRTHPLACE OF MOTHER (State or Country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Dora Kennedy

(Address) 1003 Hollins St

15- AUG 23 1920 ROBERT F. [illegible]

Filed....., 191.... [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 27th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1920, to Aug. 27 1920, that I saw her alive on Aug 27 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

(a) Entero-Colitis

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. Chas Hooker, M. D.

8/28/20, 192... (Address) 838 N. Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Aug. 29, 1920

20-UNDERTAKER	ADDRESS
John J. Fields	1300 W. Lombard

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46081 HEALTH DEPARTMENT—CITY OF BALTIMORE D46081

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH 666 Bradley St

CITY OF BALTIMORE: (No. ..... St.: 17 Ward) REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Valentine

(a) RESIDENCE. No. 666 Bradley St ..... ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Blk	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josiah Valentine

6 DATE OF BIRTH (month, day, and year) Jany 14 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Leesburg Va

PARENTS

10 NAME OF FATHER Jonah Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Leesburg Va

12 MAIDEN NAME OF MOTHER Venus Gant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Petersburg Va

14 Informant Louise Brooke

(Address) 666 W. Bradley ste.

15 Filed AUG 29 1920, 19 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 27th, 1920, to Aug 27, 1920, that I last saw her alive on Aug 27, 1920, and that death occurred, on the date stated above, at 3.50 p m.

The CAUSE OF DEATH* was as follows:

Apoplexy (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Obesity (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Gustav Goldman, M. D.

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	8/31/20
20 UNDERTAKER	ADDRESS
F B Pye	102 N Mulberry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1446 1046082 — 1046082

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 7 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME C. Harold Putnam

(a) RESIDENCE. NO. Auburn N. Y. ST.. WARD. Auburn N.Y.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Mina Putnam

6 DATE OF BIRTH (month, day, and year) Dec 29 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
36		8		

8 OCCUPATION OF DECEASED 045

(a) Trade, profession or particular kind of work Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) Metable iron

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER Franklin Putnam

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Anna Goodrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Hospital Record
(Address) J. H. H.

15 Filed AUG 29 1920 ROBERT F. KRAUTER Registrar
By ..... Deputy Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 4 1920, to Aug 28 1920, that I last saw him alive on Aug 28 1920, and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

?

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Above Aug 6th

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) Edward Hanaman Jr, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Auburn N.Y.	Aug. 29 1920
20 UNDERTAKER	ADDRESS
H E Hughes	175 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

2046083 HEALTH DEPARTMENT—CITY OF BALTIMORE 2046083

42

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 728 W Lexington ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Kraft.

(a) RESIDENCE: NO. 728 W Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? 64 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 6 - 1833

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~About~~	64	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chamber Maid.

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Henry Kraft.

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Mary Singer -

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany -

14 Informant (Address): Albert Kraft 728 W Lexington

15 Filed AUG 29 1920 ROBERT E. LAMPER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 28, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1920, to Aug 13, 1920, that I last saw her alive on Aug. 13, 1920, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

1 mo (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Schaffer, M. D.

, 19 (Address) 115 N Carey St (Balto Gen Dispy)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 30 1920
20 UNDERTAKER	ADDRESS
Wm J Uckmer Sons	North Ave

Is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D46084

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46084

CERTIFICATE OF DEATH.

X 122

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. General Hospital (St.) 11 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oliver Stonesifer

(a) RESIDENCE. NO. Alberton - Md. ST., WARD. Alberton Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Emma Stonesifer

6 DATE OF BIRTH (month, day, and year) April 2 - 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone - mason

(b) General nature of industry, business, or establishment in which employed (or employer) 075

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Uriah Stonesifer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Emma Angel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Annie Stonesifer (Address) Alberton, Howard Co. Md

15 Filed AUG 30 1920 ROBERT F. HAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29, 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 18, 1920, to Aug. 29, 1920, that I last saw him alive on Aug. 29, 1920, and that death occurred, on the date stated above, at 3.20 a. m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pyo-nephrosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? ye Date of Aug 25 1920

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) E. S. Coster, M. D.

8/24, 1921 (Address) Md. General Hospital

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Good Shepherd	Sept 1 1920
20 UNDERTAKER Easton Sons	ADDRESS Ellicott City

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46085

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46085

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 742 W. Baltimore ST.: 4 WARD) REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Baum

(a) RESIDENCE. NO. 742 W. Baltimore ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 7 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (Husband) (Wife) of Valentine Baum

6 DATE OF BIRTH (month, day, and year) Jan 1, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties 137

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Pollheim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary. Fenner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Pollheim (Address) 121 N. Fremont St.

15 Filed AUG 30 1920 ROBERT A. LAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 1919, to August 27th 1920, that I last saw her alive on August 27th, 1920, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 1 yrs. 10 mos. — ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? — No

What test confirmed diagnosis? Albumin (Ward in urine) Autopsy

(Signed) William T. Sullivan, M. D

8/28 1920 (Address) 1701 A Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL Aug 30 1920

20 UNDERTAKER Mrs Mrs John W. Teufel ADDRESS 801 W. Fayette St.

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D46086

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46086

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 S. Monroe ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margareta Eibele

(Residence in Baltimore: No. 401 S Monroe St St.; — yrs., 11 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, June 11, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 7 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....None....
(b) General nature of industry, business, or establishment in which employed (or employer) ....000....

9-BIRTHPLACE, (State or Country), Balt Md

PARENTS.

10-NAME OF FATHER, Paul Eiberle

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margerette Hild

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Eiberle

(Address) 401 S. Monroe St

15- ROBT. L. LATTA

AUG 30 1920 191.. Burial Permit Issued Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 27, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 13 1920, to Aug 27 1920, that I saw her alive on Aug 27 1920, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas A Schaefer M. D.

Aug 29, 1920 (Address) 53 E Fulton Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cem	Aug 30, 1920
20-UNDERTAKER	**ADDRESS**
Geo Steinbrenner & Son	647 N Gay St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

Pelashi

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46087 D46087

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 3 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Petastes

(Residence in Baltimore: No. 232 S. Eden St St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 27 (Day), 1920 (Year)

7-AGE, yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russian

12-MAIDEN NAME OF MOTHER Tuitkevan

13-BIRTHPLACE OF MOTHER (State or Country), Turkevan

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Petastes

(Address) 232 S. Eden

15- AUG 30 1920 ROBERT I KRAUTER

Filed ....., 191. Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 21 1920, to August 28 1920, that I saw him alive on August 28 1920, and that death occurred, on the date stated above, at 11:20 a.m.

The CAUSE OF DEATH* was as follows:

Acute intestinal decomposition

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Marasmus

(Duration) yrs. mos. ds.

(Signed) Manuel L. Gates M. D.

August 28, 1920. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 8 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Swartz Conn

DATE OF BURIAL, Aug 30, 1920

20-UNDERTAKER Stephen J Trackowski

ADDRESS 1100 S[illegible]

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46088

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46088

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 103 W 20th St. ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Liggett

(a) RESIDENCE. No. 103 W 20th St ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F/M	Col. Col	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work X

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer X

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Arthur Liggett

11 BIRTHPLACE OF FATHER (city or town) ..... N. C.
(State or country) Woodland

12 MAIDEN NAME OF MOTHER Rosie Mc Francis

13 BIRTHPLACE OF MOTHER (city or town) Suffolk
(State or country) Virginia

14 Informant Arthur Liggett
(Address) 203 W. 20th St.

15 Filed AUG 30 1920 19 ROBERT I. KRAUTER Registrar
Burial Permit Oiv'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/29/20 19

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1920, to Aug 29, 1920, that I last saw her alive on Aug 28th, 1920, and that death occurred, on the date stated above, at 5 00 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth
General Weakness and Rickets.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) ..... yrs. 7 mos. ..... ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? X Date of X

Was there an autopsy? X

What test confirmed diagnosis? X

(Signed) Geo. S. Hall, M. D.

, 19 (Address) 426 E 23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Aug. 30 1920
20 UNDERTAKER	ADDRESS
Joseph A Farrell	2317 Druid

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1009 Bks.

D46089

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46089

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 W Pratt ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emanuel Cohen

(a) RESIDENCE. NO. 1809 W Pratt ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Cohen

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
62	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 034

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery

(c) Name of employer Russia

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Aaron Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dora Caplan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant ..... (Address) Mary Cohen 1809 W Pratt St

15 Filed AUG 30 1920 19 ROBERT E. LAWTHER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/27/20 · 1920

17 Aug 27 1920

I HEREBY CERTIFY, That I attended deceased from Durin past 3 years, 19 17.

that I last saw him alive on Aug 27, 19 20

and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Theodore Lagan M. D.

Aug 25 1920 (Address) Dr Theodore Lagan

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehren Mosh Road	8/30 1920
20 UNDERTAKER Jack Lewis	ADDRESS 1411 St Paul

TION is very important. See instructions on back of ... ck of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1046090

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046090

CERTIFICATE OF DEATH.

39

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 735 E 20th ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard M. Trexler

(Residence in Baltimore: No. 735 E 20th St.; 20 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Married

6-DATE OF BIRTH, February (Month) 23 (Day), 1850 (Year)

7-AGE, 70 yrs. ..... mos. ..... da. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Painter 050
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Cumberland Md

PARENTS.

10-NAME OF FATHER, John G Trexler

11-BIRTHPLACE OF FATHER (State or Country), Cumberland Md

12-MAIDEN NAME OF MOTHER Julia Pearsman

13-BIRTHPLACE OF MOTHER (State or Country), Cumberland Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Trexler

(Address) 735 E 20th St

15-

AUG 30 1920 191..... ROBERT J. KRAUTER Registrar.

Burial Permit is Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 29 (Day), 1920 (Year)

I HEREBY CERTIFY, That I attended deceased from January 1920 to August 29 1920, that I saw h alive on August 29 1920, and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Palate

..... (Duration) 7 yrs. ..... mos. 2 9 ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) P E Filby M. D.

Aug 30 1920 (Address) 727 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cumberland Md. DATE OF BURIAL, Aug 30, 1920

20-UNDERTAKER E A Weidefeld Jr. ADDRESS Frem MV Md.

Please follow the instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46091 HEALTH DEPARTMENT—CITY OF BALTIMORE D46091

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hosp. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hepler

(a) RESIDENCE. No. 109 Park Avenue ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 29 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			2 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Chas. Hepler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Chas Hepler
(Address) 109 Park Ave

15 Filed ... 19 ... ROBERT E. LEACH Registrar

AUG 30 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1920, to Aug 29, 1920, that I last saw h.s alive on Aug 29, 1920, and that death occurred, on the date stated above, at 12:15 m.

The CAUSE OF DEATH* was as follows:
Premature birth

... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dudley P. Bauer, M. D.

. 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	aug 31 1920
20 UNDERTAKER Williams Cook	ADDRESS 502 E Fath

Note—It is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

Mollie Dowell.

D46092

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46092

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 William ST.; 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mollie Dowell

(a) RESIDENCE. NO. 1104 Williams ST., WARD. 24

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 5 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Geo. H. Dowell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Frances Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Robt. L. Dowell. (Address) 815 St. Charles

15 Filed AUG 30 1920 19 ROBERT A. LIMPERT Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 29 1920

17 I HEREBY CERTIFY, That I attended deceased from July 27 1920 to Aug 29 1920 that I last saw h[illegible] alive on Aug 26 1920 and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

Over

(duration) about 4 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) 2 1

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Dawson, M. D.

. 19 (Address) 1316 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Aug 31 1920

20 UNDERTAKER: Wm Crooks — ADDRESS: W + G Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046093 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046093

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 15-170

CITY OF BALTIMORE: (No. 1602 Lorman ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Isabelle Braxton

(a) RESIDENCE. NO. 1602 Lorman ST., 15th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Braxton

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
50		—	—	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work House keeper

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Miss Lucretia Ridgway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mr. James Braxton
(Address) 1602 Lorman St.

15 FILED AUG 30 1920 BOWERY B. REUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27. 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1920, to Aug 27th 1920, that I last saw her alive on Aug 27th 1920, and that death occurred, on the date stated above, at 2.00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Uremic Poisoning

12 hrs. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) 3 yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology

(Signed) James Edw. Bell M. D.

8-27 1920 (Address) 1505 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Aug 30 1920
20 UNDERTAKER	ADDRESS
Sam'l. Chase Son	1400 Mad.

Spec.—8-24-14—M. & T.—2000 Blks.

D46094 HEALTH DEPARTMENT—CITY OF BALTIMORE D46094

CERTIFICATE OF DEATH.

1921 REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1842 Mc Henry ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine E. Dunkle

(Residence in Baltimore: No. 1842 Mc Henry St ST.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, ... July (Month) 24 (Day), 1920 (Year)

7-AGE, ... yrs. 1 mos. 5 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm J Dunkle

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Anna Brogan

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm J Dunkle

(Address) 1842 Mc Henry St

15- AUG 30 1920 ROBERT P LAZENBY Registrar. Filed ..... 191... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 29 1920, to Aug 29 1920, that I saw her alive on Aug 29 1920, and that death occurred, on the date stated above, at 8 30 a. m.

The CAUSE OF DEATH* was as follows:

Stillborn Cause unknown

..... (Duration) ..... yrs. ..... mos. 2 hours ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ralph A Muse M. D.

Aug 29 1920 (Address) 1520 Hollins St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem

DATE OF BURIAL, 8-30th, 1920

20-UNDERTAKER Herbert F Booth & Son

ADDRESS C. E. Cor Calhoun & Hollins

Over

D46095 HEALTH DEPARTMENT—CITY OF BALTIMORE D46095

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 118 S Ellwood ST.; WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Laird

(Residence in Baltimore: No. 118 S Ellwood av St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Boy

6-DATE OF BIRTH, Aug (Month) 25 (Day), 1920 (Year)

7-AGE, ... yrs. ..... mos. 3 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Louie Laird

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Edna Meyers

13-BIRTHPLACE OF MOTHER (State or Country). N. J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louie Laird

(Address) 113 S. Ellwood av

15- FILED AUG 30 1920 191.... ROBERT B KEJUTER CHIEF CLERK Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 27 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

8-28, 1920 (Coroner) (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem DATE OF BURIAL, 8/30, 1920

20-UNDERTAKER J. A. Moran ADDRESS 3000 E. Balto St.

important. See instructions on back of certificate.

D46096

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46096

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Standard Guano Co. REGISTERED No. C 15-175

CITY OF BALTIMORE (No. Curtis Bay. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Alexander.(C).

(Residence in Baltimore: No. 1818 N. Carey Street. St.: 16 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH, Do not know. (Month) (Day), 1878 (Year)

7-AGE, 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, Poppy Alexander.(C).

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER Madalein Alexander.(C).

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Dennis.(C).

(Address) 1303 Prestman St.

15- AUG 30 1920 191 ROBERT B. ELLIOTT Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 27th, 1920. (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suffocation.
Accidentally buried under pile of guano.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto W. Reinhardt M. D.
(Coroner)

Aug., 29th., 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Zion Cem	Aug 30 1920

20-UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST

important. See instructions on back of certificate. Each statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046097 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046097

CERTIFICATE OF DEATH. 108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen'l Hosp ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Martin Lee

(a) RESIDENCE. No. 624 Brian St (r) ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 4 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 15th 1898

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
22	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer West End Confectionery

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John J. Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Enright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs Ellen Lee (Address) 624 Brice St

15 Filed AUG 30 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1920. to Aug 29 1920. that I last saw him alive on Aug 29, 1920, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

2 wks. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Aug. 29, 1920

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Joseph P. Ponte Jr., M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Sept 1st 1920
20 UNDERTAKER John J. Cowan & Son	ADDRESS 1111 Pine St

Burial Permit Clerk

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D46098

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46098

CERTIFICATE OF DEATH.

REGISTERED NO. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 778 Sarah Ann ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milton Gray

(Residence in Baltimore: No. 778 Sarah ann St.; yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Jan (Month) 14 (Day), 1919 (Year)

7-AGE, 1 yrs. 5 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——— ooo
(b) General nature of industry, business, or establishment in which employed (or employer) ———

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Charles Gray

11-BIRTHPLACE OF FATHER (State or Country). Balto

12-MAIDEN NAME OF MOTHER Virginia Gray

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Banks

(Address) 780 Sarah ann St

15-

Filed AUG 30 1920 191.... ROBERT J. KRUTH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 27 1920, to Aug 29 1920, that I saw h in alive on Aug 29 1920, and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Diarrhea and Enteritis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

8/30, 1920 (Address) 739 George

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn

DATE OF BURIAL, Sept 1, 1920

20-UNDERTAKER David Everlon

ADDRESS 916 Penna ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 46099 HEALTH DEPARTMENT—CITY OF BALTIMORE D 46099

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 760 E 20 36 St.; 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hestor Ford

(Residence in Baltimore: No. 760 E 36 St.; 77 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widow

6-DATE OF BIRTH, ? (Month) (Day), 1843 (Year)

7-AGE, 77 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Balto City

PARENTS.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm R Handy

(Address) 760 E 36 St

15-

Filed AUG 30 1920, 191.

ROBERT B [illegible]
Burial Permit [illegible]
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 25 1918, to Aug 28 1920, that I saw her alive on Aug 27 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Chr Bronchitis + Endo Carditis

(Duration) Some yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ✓ yrs. ✓ mos. 5 ds.

(Signed) Dr R W Mifflin M. D.

Aug 29, 1920 (Address) 1016 Madison Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem — DATE OF BURIAL, Aug 30 1920

20-UNDERTAKER David Easters — ADDRESS 916 Pa Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 46100

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46100.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH (a) Church Home & Infirmary 19 114 REGISTERED NO.

CITY OF BALTIMORE: (No. N. Broadway ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Charles Hershfeld

(a) RESIDENCE. NO. 2813 Park View Terrace ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, ~~Widowed~~, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Alice Hershfeld

6 DATE OF BIRTH (month, day, and year) June 14, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Wagon Builder

(c) Name of employer Conestoga Wagon Mfg Co. Philadelphia Pa.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Charles N Hershfeld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Armeling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs Alice N Hershfeld

(Address) 2812 Park view Terrace

15 Filed AUG 30 1920 19 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27. 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 7. 1920. to Aug 27. 1920.

that I last saw him alive on Aug 27. 1920.

and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Toxemia Chole cystitis & Cholelithiasis

(duration) 2 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Post Operative adhesions with Intestinal obstruction.

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 10, 1920

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. D. Noble, M. D.

19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Aug 31st 1920

20 UNDERTAKER John B. Spence ADDRESS 1325 N. Caroline St

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D46101

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D46101

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2520 Eastern Ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Novak

(Residence in Baltimore: No. 2520 E. Ashland Ave St.; ..... yrs., 6 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Infant

6-DATE OF BIRTH, Feb (Month) 28 (Day), 1920 (Year)

7-AGE, 6 yrs. 2 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Frank Novak

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary Fcarek

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Novak

(Address) 2520 Eastern Ave

15-

Filed AUG 30 1920, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 3 1920, to Aug 29 1920, that I saw him alive on Aug 29 1920, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank J Ayd M. D.

Aug 30, 1920 (Address) 2005 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Aug 31, 1920

20-UNDERTAKER Frank Ewert & Son

ADDRESS 1906 Eastern Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

Housek

D 46102

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46102

CERTIFICATE OF DEATH.

8 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Joseph Housek

(a) RESIDENCE. NO. 2247 Chase ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Mary

6 DATE OF BIRTH (month, day, and year) Oct 15, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Policeman

(b) General nature of industry, business, or establishment in which employed (or employer) 061

(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) (State or country) ~~Bohemia~~ Baltimore

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Kate Lucian

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Mary Housek (Address) 2247 E Chase st

15 Filed AUG 30 1920 Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1920

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1920, to Aug 28, 1920, that I last saw h[illegible] alive on Aug 28, 1920, and that death occurred, on the date stated above, at 1:17 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of July 16, 1920

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. G. Chamberlain M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	Sept 1920
20 UNDERTAKER Frank E Enoch Son	ADDRESS 1906 E Baltimore

TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

046103. HEALTH DEPARTMENT—CITY OF BALTIMORE 046103.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1922 McCulloh ST.; 17 WARD) REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Henry

(a) RESIDENCE. No. 1922 McCulloh ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced (or) WIFE of Annadon Henry

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE about 63 Years ~~Months~~ Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED 070

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Housekeeper.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER George Curry.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Payne.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant John B. Curry
(Address) 1922 McCulloh.

15 Filed AUG 30 1920 19 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1920

17 I HEREBY CERTIFY, That I attended deceased from June 22 1920, to Aug 28 1920, that I last saw her alive on Aug 28 1920, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary findings

(Signed) E William Fray, M. D.

8/28 1920 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Salem N J.	8/31/20.

20 UNDERTAKER E B Pye ADDRESS 102 E Mulberry.

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D46104 HEALTH DEPARTMENT—CITY OF BALTIMORE D46104

CERTIFICATE OF DEATH.

REGISTERED No. C 8

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2227 Lamb ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Schoeler

(Residence in Baltimore: No. 2257 Lamb St.; yrs. 8 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	S

6-DATE OF BIRTH December 21, 1919 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
yrs. 8 mos. 7 ds.	hrs. or mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John H. Schoeler

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Era Vogel

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Era Schoeler

(Address) 2257 Lamb St

15- AUG 30 1920 Filed ....., 191.....

[illegible] & LAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 29, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 10 1920, to Aug 28 1920, that I saw h[illegible] alive on August 28 1920, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Dr Whooping Cough

(Duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Enteritis & Bronchitis

(Duration) yrs. mos. ds.

(Signed) Frank J. Ayd M. D.

Aug 29, 1920 (Address) 2005 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Mathews Cem	Aug 30, 1920
20-UNDERTAKER Geo C Muller	ADDRESS 2334 Jeffers

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46105

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46105

14

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4136 Falls Road) (13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Greene

(a) RESIDENCE. No. 4136 Falls Road ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John L. Greene

6 DATE OF BIRTH (month, day, and year) 10/25/1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Cullum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Geo. N. Greene

(Address) 962 N. 37th St.

15 AUG 30 1920 [illegible] Registrar

[illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/29 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1920, to Aug 29, 1920, that I last saw h[illegible] alive on Aug 29, 1920, and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Stools

(Signed) R. L. Howard M. D.

9.30. 1920 (Address) 3543 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Sep 2 1920
20 UNDERTAKER	ADDRESS
Chenoweth Son	Chestnut Ave

THION is very important. See instructions on back of certificates. Exact statement of OCCUPA- ay be properly classified, so that it may be

Spec.—6-9-19—H. P. Co.—1000 Bks.

2046106

HEALTH DEPARTMENT—CITY OF BALTIMORE

2046106

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3500 Roland Ave St. 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margret M Wilhelm

(a) RESIDENCE. NO. 3500 Roland Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1 1920

7 AGE Years / Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Clarence Wilhelm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maud Madeira

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Clarence Wilhelm 3500 Roland Ave

15 Filed AUG 30 1920 19 BUREAU OF STATISTICS Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 25 1920, to Aug 28, 1920, that I last saw h[er] alive on Aug 28, 1920, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Malnutrition - stomatitis - leukemia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Pus in urine & stool, tumor in vomitus.

(Signed) Wm F Kelly M. D.

8/29 1920 (Address) 3705 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Aug 30 20

20 UNDERTAKER Chenoweth & Son ADDRESS Chestnut Ave

Hour is very important. See instructions on back of certificates. Exact statement of OCCUPA

Spec.—8-24-14—M. & T.—2000 Bks.

046107 HEALTH DEPARTMENT—CITY OF BALTIMORE 046107

39

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2408 Hilldale ST.; 20 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred M Smith

(Residence in Baltimore: No. 2408 Hilldale ave St.; 19 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April (Month) 28 (Day), 1849 (Year)

7-AGE, 71 yrs. 4 mos. 00 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE, (State or Country), Elkton Md

PARENTS.

10-NAME OF FATHER, James R Smith

11-BIRTHPLACE OF FATHER (State or Country), Elkton Cecil Co Md

12-MAIDEN NAME OF MOTHER Caroline Matthews

13-BIRTHPLACE OF MOTHER (State or Country), Delaware

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs C. B. Smith

(Address) 2408 Hilldale Ave

15- AUG 30 1920 Filed....., 191.. ROBERT I. LAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 10 1920, to Aug 29 1920, that I saw h in alive on Aug 29 1920, and that death occurred, on the date stated above, at 6 45 P.m.

The CAUSE OF DEATH* was as follows:

Carcinomata of Left Jaw

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Robert C Duvall M. D.

Aug 30, 1920 (Address) 2150 Hilldale Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Elkton Md	Sept 1st, 1920
20-UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46108

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46108

152

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Jos Hosp. (St.: 9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Eckert

(a) RESIDENCE. No. Finksburg Md St.. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	wh.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 29 '20

7 AGE Years Months Days 1 If LESS than 1 day, 9 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St Jos Hosp.
(State or country)

PARENTS

10 NAME OF FATHER Robt Eckert

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Taneytown Md

12 MAIDEN NAME OF MOTHER Ivie Little

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Silver Run Md

14 Informant. Milton F. Little
(Address) Finksburg Md

15 Filed Aug 30, 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 19 20, to Aug 29, 19 20, that I last saw him alive on Aug 29 - 3PM, 19, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank C. Marino M. D.

, 19 (Address) St Jos Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Silver Run Cemetery Carroll Co Md	Sept 1 1920
20 UNDERTAKER	ADDRESS
J. F. Elsire	Reisterstown Md

Fold here if you wish to keep this certificate clean. Please read carefully the instructions on back of certificates. They are very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46109

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46109

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 S. Norris ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella L. Schneider

(a) RESIDENCE. No. 218 S Norris ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 19-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	5	20	

8 OCCUPATION OF DECEASED

037

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Joseph Schneider (Address) 218 S Norris

15 Filed AUG 30 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1920, to Aug 29, 1920, that I last saw h alive on Aug 29, 1920; and that death occurred, on the date stated above, at 12 1/2 m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Ast. Obstruction

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At Home of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) T. H. Vincent, M. D.

8/29, 1920 (Address) 1302 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 1 1920
20 UNDERTAKER	ADDRESS
John J. Fields	1200 W Lombard

THIS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46110 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46110

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry C. McNamara

(a) RESIDENCE: NO. S. W Cor. 25th and Greenmount STS. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella McNamara

6 DATE OF BIRTH (month, day, and year) Feb. 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER John McNamara

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Adaline Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed AUG 30 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 29, 1920

17 I HEREBY CERTIFY, That I attended deceased from August 25, 1920, to August 29, 1920, that I last saw him alive on August 29, 1920, and that death occurred, on the date stated above, at 1:10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) R Bateman, M. D.

8/30/20 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~	DATE OF BURIAL
Greenmount	Aug 31 1920
20 UNDERTAKER Geo W Little	ADDRESS 531 N Fremont Av

TION is very important. See instructions on back of certificates.

D.46111 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46111

CERTIFICATE OF DEATH.

161

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Munsey Building, ST., 11 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Hopdan

(Residence in Baltimore: No. 626 n Calvert. St.) 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	Colored	S.

6-DATE OF BIRTH, ..., 1880.
(Month) (Day) (Year)

7-AGE, 48 yrs. mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): Munsey Bldg.

9-BIRTHPLACE, (State or Country), County Tyrone Ireland.

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Moore

(Address) 1821-Aisquith St

15- Filed AUG 30 1920, 191.....

Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 26, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Jumping Down stair Shaft

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Fred Jones M. D.
(Coroner.)

8-27-, 1920 (Address) 4 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemetery

DATE OF BURIAL, 8/31, 1920.

20-UNDERTAKER George D. Ruth

ADDRESS 1735-Hanford

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.46112

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46112

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 576 Oxford ST.; 17 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Inlow

(Residence in Baltimore: No. 576 Oxford St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, Feb (Month) (Day), 1845 (Year)

7-AGE,	If LESS than 1 day,
75 yrs. 6 mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry Parker

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Eliza Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B. B. Brooks

(Address) 405 Robert

15- Filed AUG 30 1920, 191.. Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 28 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 27 1920, to Aug 28 1920, that I saw h[illegible] alive on Aug 27 1920, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Mitral disease of heart

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(Duration) yrs. mos. ds.

(Signed) William E. Burton M. D.

Aug 29, 1920 (Address) 2122 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Brooks Cemetery — DATE OF BURIAL, Aug. 31, 1920

20-UNDERTAKER Calvert Co. Md John H. Trader — ADDRESS 142 W. Hill St

D.46113 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46113

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 815 n wolf St.: 7 Ward) REGISTERED No. C

2-FULL NAME George L. Yent—
(Residence in Baltimore: No. 815 n wolf

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

51 St.; yrs., 11 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED: (Write the word.) Married

6-DATE OF BIRTH: September 7, 1869
(Month) (Day) (Year)

7-AGE: 51 yrs. 11 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Huckster
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles Yent.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Elizabeth Mrs Kelly

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Yent

(Address) 813 N. Wolfe St

15- Filed AUG 8 0 1920, 191.... Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: ....Aug....29....., 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.....(Inquest, autopsy or inquiry.) and that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) W. F. Hurley M. D.
(Coroner.)

S. 30 191 2 (Address) 9 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL: Greenmount Cemetery Cedar Grove Cem

DATE OF BURIAL, 19..20: Aug 31

20-UNDERTAKER: William J. Hurley

ADDRESS: 815 4 Washington

important. See instructions on back of certificate.

D.46114

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 46114

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2101 Hanover Street. ST.: 23 WARD) 79

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis L. Meyers.

(Residence in Baltimore: No. 2101 Hanover Street. St.: yrs., mos. ds.)

15 ----------.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, September 19th, 1865., 1 (Month) (Day) (Year)

7-AGE, 54 yrs. 11 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Labrer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), France.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Meyers. (wife).....

(Address).....2101 Hanover Street.

15-

Filed AUG 30 1920, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 28th, 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Aug., 30., 1920 (Address) 1017. S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Aug. 31. 1920

20-UNDERTAKER Margaret J. Flynn ADDRESS 1422 Light St.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.46115

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46115

CERTIFICATE OF DEATH.

105

1-PLACE OF DEATH Little Sisters of the Poor REGISTERED NO. C.....

CITY OF BALTIMORE: (NO..... ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Burk

(Residence in Baltimore: No. 0 St.; 46 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Wid

6-DATE OF BIRTH, ... (Month) Unknown (Day), 1 (Year)

7-AGE, about 75 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Morgan Brennan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Margaret Brennan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed ..... Aug. 30 1920 ..... Robt. T. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug. (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from No record 191..., to ..... 191...,

that I saw h[er] alive on Aug 29 1920,

and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

.....

..... Diarrhea

..... 6 Days (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... F. A. Warne, M. D.

Aug. 30, 1920 (Address) 1133 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 11 yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross Cem	Aug. 31., 1920
20-UNDERTAKER M. D. Flynn	ADDRESS 1425 Light St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D46116

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46116

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 47 E Heath ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles R. Burgess

(a) RESIDENCE. NO. 47 E Heath ST., 23 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 8 mos. 18 ds. How long in U. S., if of foreign birth? 60 yrs. 8 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie R Burgess

6 DATE OF BIRTH (month, day, and year) Dec. 11/1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	8	18	

045

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dry Dock

(b) General nature of industry, business, or establishment in which employed (or employer) Store Keeper

(c) Name of employer Balto Dry Dock

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Burgess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard County

12 MAIDEN NAME OF MOTHER Sarah Sheet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co.

14 Informant Wm Burgess

(Address) 47 E Heath St

15 Filed AUG 31 1920 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 22 1920 to Aug 29 1920 that I last saw h alive on Aug 29 1920 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Delirium

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R E Campbell M. D.

(Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 1920

20 UNDERTAKER J. Fen. McCully ADDRESS 130 C. Portal

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1423 X046117 — 104 — X046117

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Leonard

(a) RESIDENCE. No. 1510 N. Dallas ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 28, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER F. Fitzpatrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Frances Leonard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Hospital Record
(Address) J. H. H.

15 Filed AUG 31 1920 ROBERT B. BRAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1920, to Aug 30, 1920, that I last saw h[illegible] alive on Aug 30, 1920, and that death occurred, on the date stated above, at 2 00 m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Private home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept. 1920
20 UNDERTAKER	ADDRESS
Leo D. Cook	Garth & Blaylock.

Note—Very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

L46118 HEALTH DEPARTMENT—CITY OF BALTIMORE L46118

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1735 Lancaster St.; 2 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Buchniewski

(Residence in Baltimore: No. 1735 Lancaster St.; 1 yrs., 3 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Infant

6-DATE OF BIRTH, June (Month) 2 (Day), 1919 (Year)

7-AGE, 1 yrs. 2 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Felix Buchniewski

11-BIRTHPLACE OF FATHER (State or Country), Germy

12-MAIDEN NAME OF MOTHER Carrie Schmisher

13-BIRTHPLACE OF MOTHER (State or Country), Balt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Felix Buchniewski

(Address) 1735 Lancaster

15- AUG 31 1920 ROBERT P KRAUTER

Filed....., 191.... Registrar of Deaths

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 23 1920, to Aug. 29 1920, that I saw him alive on Aug 27 1920, and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) /

(Duration) yrs. mos. ds.

(Signed) John H. Kehlberger M. D.

Aug. 29, 1920 (Address) 1709 Aliceanna

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary Cemetery Rd DATE OF BURIAL, Aug 31, 1920

20-UNDERTAKER Wendell Duffield & Son ADDRESS 31 S Pine

Spec. 6-9-19 H. P. Co.—1000 Bks.

1046119

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046119

CERTIFICATE OF DEATH.

152

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 Hurbert ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Teal.

(a) RESIDENCE. No. 2104 Hurbert ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: Colrd

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 29 20

7 AGE: Years | Months | Days | If LESS than 1 day 20 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Elmer E Teal.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Hattie M. Welling

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Elmer E Teal
(Address) 2104 Hurbert St

15 Filed AUG 31 1920 Registrar ROBERT J. KNOTT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/30/20

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1920, to Aug 30, 1920

that I last saw h.. alive on Aug 30, 1920,

and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia
Pallida (duration) yrs. 20 hrs mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Mellon M. D.

8/30/20 (Address) 2757 W North av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cemetery

DATE OF BURIAL: Sept 1 1920

20 UNDERTAKER: W M Ronton

ADDRESS: 2235 W North ave

Keep this space free for indorsements. Read instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46120

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1042 D46120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 S Regester ST.; 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Rytel

(a) RESIDENCE. No. 418 S Regester ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 20 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Rytel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Marjeanna Grubelska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Marjeanna Grubelska (Address) 418 S Regester St

15 Filed AUG 31 1920 19 ROBERT P. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1920, to Aug. 30, 1920; that I last saw him alive on Aug. 29, 19..., and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Ileo-colitis

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) A. J. Bredeck M. D.

19 (Address) 918 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	August 31 1920

20 UNDERTAKER John H. Weber ADDRESS 1803 Bank St

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46121 D46121

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 454 Spring st ST.; 5 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Garner

(Residence in Baltimore: No. 415 N Spring st St.; 55 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (*Write* the word.) Married

6-DATE OF BIRTH, March 5, 1865 (Month) (Day) (Year)

7-AGE, 55 yrs. 5 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer in Pottery
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), St Marys County Maryland

PARENTS.

10-NAME OF FATHER, Robert Garner

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER not known,

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Matilda Burke

(Address) 454 N Spring st

15-

DOROTHY B KRAUTER

Filed AUG 4 1920, 191...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 28, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 14 1920, to August 28 1920, that I saw h~~im~~ alive on August 28 1920, and that death occurred, on the date stated above, at 9.15 a.m.

The CAUSE OF DEATH* was as follows:

Edocarditis Interstitial Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. 1 mos. ds.

(Signed) Richard McCandlish M. D.

August 29 1920. (Address) 451 E Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel

DATE OF BURIAL, ..., 191...

20-UNDERTAKER John W Henderson

ADDRESS 1302 E Monument

Spec.—8-24-14—M. & T.—2000 Bks.

D46122

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46122

CERTIFICATE OF DEATH.

8 170

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1320 E. Chester ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo W. Norwood

(Residence in Baltimore: No. 1320 N. E. Chester St.; 64 yrs. 2 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, June (Month) 14 (Day), 1856 (Year)

7-AGE,	If LESS than 1 day,
64 yrs. 2 mos. 15 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar maker
(b) General nature of industry, business, or establishment in which employed (or employer): 084

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Richard Norwood

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Tuck

13-BIRTHPLACE OF MOTHER (State or Country), Unk

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. Norwood

(Address) 1320 N. Chester st

15- AUG 31 1920 Filed....., 191... ROBERT E. LEAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to Aug 29 1920, that I saw h... alive on Aug 28 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

..... (Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Insenesia

..... (Duration) yrs. mos. 2 ds.

(Signed) John T. Carey M. D.

....., 191... (Address) 1603 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mount Carmel	Aug. 31., 1920

20-UNDERTAKER	ADDRESS
Henry Lutz	1007 N. Bond

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 46123

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46123

CERTIFICATE OF DEATH.

81

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3507 N. Charles ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah L. Foster

(a) RESIDENCE. No. 3507 N. Charles ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 40 yrs. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Reuben Foster

6 DATE OF BIRTH (month, day, and year) 1844-6-8

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76 years	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Cape May New Jersey

PARENTS

10 NAME OF FATHER Parsons Hand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cape May N. J.

12 MAIDEN NAME OF MOTHER Mary Carll Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cape May N.J.

14 Informant Edmund Foster

(Address) 924 Equitable Bldg

15 Filed AUG 31 1920 ROBERT E. LAZENBY Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1920

17 I HEREBY CERTIFY, That I attended deceased from June 15 1920, to Aug 29 1920, that I last saw h[er] alive on Aug 29 1920, and that death occurred, on the date stated above, at 11:35 a m.

The CAUSE OF DEATH* was as follows:

Cerebral arteriosclerosis

own

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) Neb Hubert, M. D.

19 (Address) 1008 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Aug 31 1920
20 UNDERTAKER	ADDRESS
Henry W. Jenkins Sons Co	[illegible]

THIS is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D46124

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46124

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 George ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Maloney

(Residence in Baltimore: No. 625 George St.; ..... yrs., 4 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH. June 18, 1855
(Month) (Day) (Year)

7-AGE. 65 yrs. 2 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Maid
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). New York

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gay Campbell

(Address) 625 George St

15-

Filed AUG 31 1920 191.....

ROBERT F. KRAUTER
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 30—20, 191...
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5-20 191... to July 30-20 191..., that I saw her alive on July 29 1920, and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Cancinoma of breast
with Secondary Metastasis

..... (Duration) yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) John C. Stewart M. D.

7-30-20 (Address) 707 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Pine Orchard Md

19-PLACE OF BURIAL OR REMOVAL, Pine Orchard Cemetery — DATE OF BURIAL, Aug. 31, 1920

20-UNDERTAKER George H. Holland — ADDRESS 1631 Bruns St

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46125 — 64 D 46125

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Homestead ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alonzo A. Moore

(a) RESIDENCE. No. 1715 Homestead ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 3 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Laura L Moore

6 DATE OF BIRTH (month, day, and year) April 30th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Police Officer

(b) General nature of industry, business, or establishment in which employed (or employer) 061

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George W. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Boston Mass.

12 MAIDEN NAME OF MOTHER Elizabeth Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Laura L Moore
(Address) 1715 Homestead st

15 Filed ..... 19 ..... ROBERT B [illegible] Registrar

AUG 31 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1920

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1920, to Aug. 29, 1920, that I last saw him alive on Aug. 29, 1920, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

General Arterio-sclerosis
Cerebral apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Oedema of lungs,

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Wm J Kelsey M. D.

. 19 (Address) 701 N Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 1st 1920
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

D 46126

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46126

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 E. Chase St.; 10 WARD) REGISTERED NO. C 45

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 10.)

2-FULL NAME Charles J. McShane

(Residence in Baltimore: No. 710 E. Chase St.; Yrs. Life Mos. Lives Ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Dec. 11, 1865
(Month) (Day) (Year)

7-AGE. 54 yrs. 8 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watchman 062
(b) General nature of industry, business, or establishment in which employed (or employer): P.O. Office

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Chas McShane

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Bridget Tighe

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine McShane

(Address) 710 E. Chase

15- Filed AUG 31 1920, 191.... ROBERT B KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, aug 29 to 11, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 22 1920, to aug 28 1920, that I saw h in alive on aug 28 1920, and that death occurred, on the date stated above, at 10.32 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Prostate Gland

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 2 ds.

(Signed) Wm. S. Hamilton M. D.

aug 29, 1920 (Address) 1216 W Cam-

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL. 9-1-1920

20-UNDERTAKER C. F. Evans & Sons

ADDRESS 118-120 Mt Royal

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46127 ✓ 104 D46127

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 435 S. Gilmor St.; 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret F. Walsh

(Residence in Baltimore: No. 1435 S. Gilmor St.; 1 yrs., 2 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 22 (Day), 1920 (Year)

7-AGE, 1 yrs. 2 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Jefferson J. Walsh Jr

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Margaret M. Schaltzky

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jefferson J. Walsh Jr

(Address) 1435 S. Gilmor St.

15- AUG 31 1920

Filed....., 191.. ROBERT J. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 29 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 26 1920, to Aug 29 1920, that I saw h..... alive on Aug 29 1920, and that death occurred, on the date stated above, at 7.50 p.m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(Duration)..... yrs..... mos. 4 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) 0 yrs. mos. 1 ds.

(Signed) Norbert C. Zubek M. D.

Aug 31., 1920 (Address) 2151 Guilford Ave

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Aug. 31., 1920
20-UNDERTAKER	ADDRESS
Geo. E. Schnvat & Bro	510 Park Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D46128 ✓ D46128

X 45

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital, ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Hodges.

(a) RESIDENCE. NO. Annapolis, Md. ST., WARD. Annapolis Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mrs M. Hodges.

6 DATE OF BIRTH (month, day, and year) Aug 8, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Business

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Hodges

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER ANN MATILDA HARWOOD Mrs Harwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant University Hospital Records

(Address)

15 Filed AUG 31 1920 ROBERT R. REACTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31, 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 16, 1920, to Aug. 31, 1920, that I last saw h. liv alive on Aug. 31, 1920, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia Cerannoma

Prostate (duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Nov 20, 1919

Did an operation precede death? yes. Date of { May 1 1920 / April 5, 1920

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos F. Horine, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prince Frederick-Calvert Co. Md X	9/2 1920
20 UNDERTAKER	ADDRESS
Henry W. Means & Son	805 N. CALVERT St.

X Via Automobile Hearse

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46129 D46129

CERTIFICATE OF DEATH.

7 151

1-PLACE OF DEATH Hebrew Hospital. REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 6 E Monument St ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Purzer

(Residence in Baltimore: No. 16 W. Read St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White	

6-DATE OF BIRTH, ... August (Month) 30 (Day), 1920 (Year).

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 2 hrs. or 15 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——— 000
(b) General nature of industry, business, or establishment in which employed (or employer) ———

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, J. Frank Purzer

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md

12-MAIDEN NAME OF MOTHER, Nora Mc. Neal-

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother- Mrs Nora Mc. Neal

(Address) 16 W. Read St.-

15- AUG 31 1920 Filed ....., 191..... ROBERT B. KELLUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... August (Month) 30 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Aug 30 - 1920, to Aug 30 1920-, that I saw him alive on 7 pm Aug 30 1920-, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

..... Premature birth.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Unknown

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ernest Edlavitch M. D.

Aug. 31, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? ———

Former or usual residence ———

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cemetery	8/31, 1920
20-UNDERTAKER Henry W. Meas & Son	ADDRESS 508 N. Gilmor St

D46130

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

104

D46130

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 46 West West St ST. 23 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Joseph Martin

(Residence in Baltimore: No. 46 W West St St.: yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
male	colored	single

6 DATE OF BIRTH Jan (Month) 26 (Day), 1919 (Year)

7 AGE 1 yrs. 7 mos. 4 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work not any
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Adolphus Martin

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Gertrude Byas

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gertrude Byas

(Address) 46 W West St

15 FILED AUG 31 1920 ROBERT I KRAUTER Burial Permit Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug (Month) 30th (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23rd, 1920, to, Aug 30 1920, that I saw him alive on Aug 26 1920, and that death occurred, on the date stated above, at 9:a m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ..... yrs. ..... mos. 10 ds

Contributory (SECONDARY) Toxemia (Duration) ..... yrs. ..... mos. 5 ds.

(Signed) B B Burton M. D.

Aug 30, 1920 (Address) 301 E Cross St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt Auburn Cem | DATE OF BURIAL Aug 31, 1920

20 UNDERTAKER David Easton | ADDRESS 916 Pa ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D46131 HEALTH DEPARTMENT—CITY OF BALTIMORE D46131

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 921 Pendleton St.: 17 WARD) REGISTERED No. C 19

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anderson Shifa

(Residence in Baltimore: No. 921 Pendleton St.: 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, May 20, 1877 (Month) (Day) (Year)

7-AGE, 43 yrs. 3 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): (General)

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Anderson Shifer

(Address) 921 Pendleton St.

15- Filed AUG 31 1920 191.... ROBERT B. CRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 29, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Hemmeter M. D. (Coroner.)

August 30 1920 (Address) 1202 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Pt. Auburn Cem. DATE OF BURIAL, Aug 31, 1920

20-UNDERTAKER Daniel Easton ADDRESS 916 Pa ave

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D146132 D146132

28

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. City Hospital, Bay View WARD) 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia West. Born Tilley

(a) RESIDENCE. NO. 1404 Bond Alley ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black.	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Unknown 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co Md.

PARENTS

10 NAME OF FATHER Joseph Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records. (Address) City Hospital, Bay View

15 Filed AUG 31 1920 ROBERT B KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26, 1920.

17

I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1920, to Aug. 26, 1920, that I last saw her alive on Aug. 26, 1920, and that death occurred, on the date stated above, at 8 20 P.m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test

(Signed) R. B. Herman, M. D.

Aug 26. 1920 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fort Auburn Cemetery	Sept 1 1920
20 UNDERTAKER	ADDRESS 1725 Ashland Ave
Mrs Rollo a Miller	

THIS IS very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D46133 HEALTH DEPARTMENT—CITY OF BALTIMORE D46133

38

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 236 S. Bethel ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte Matilda Gilson

(Residence in Baltimore: No. 236 S. Bethel St St. 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug 8th, 1879 (Month) (Day) (Year)

7-AGE, 41 yrs. 0 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm H Jones

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Elizabeth Hicks

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Drasopbson

(Address) 23 S Bethel St

15- AUG 31 1920 ROBERT B. ERAUTER

Filed....., 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 28th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 20th 1920, to Aug 28 1920, that I saw her alive on Aug 28 1920, and that death occurred, on the date stated above, at 1.20 P.M.

The CAUSE OF DEATH* was as follows: over

Acute General Peritonitis

..... (Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis

..... (Duration) ? yrs. ? mos. ds.

(Signed) J. H. Lamond M. D.

Aug 28, 1920 (Address) 140 W Hill St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Carrollton Cmty — DATE OF BURIAL, Aug 31, 1920

20-UNDERTAKER Mrs Robt Arndt — ADDRESS 1726 Aisdandan

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D46134 X64 D46134

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 121 N Mount St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Kelly

(a) RESIDENCE. No. 121 N Mount St., 19 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. about 6 mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82		—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Lurarne Kelley

(Address) 121 N. Mount St

AUG 31 1920 ROBERT E. LEACH Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Apr 20, 1920, to Aug 29, 1920, that I last saw h alive on Aug 28, 1920, and that death occurred, on the date stated above, at 9:50 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. 5 mos. — ds.

18 Where was disease contracted if not at place of death? Whitestone Va

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. W. Wenner, M. D.

Aug 31, 1920 (Address) 1502 E Fountain

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lancaster Whitestone Va.	Aug 31 1920
20 UNDERTAKER Wharf	ADDRESS
Edw. Ringgold	1463 N. Carey St

How to be very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D46135 D46135

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1434 John ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret A. Seppler

(Residence in Baltimore: No. 1434 John St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, March (Month) 21 (Day), 1846 (Year)

7-AGE, 74 yrs. 5 mos. 8 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, James Grady

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Rielly

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mary Jane Seppler

(Address) 1434 John St.

15-

Aug 31 1920 ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 7, 1920, to Aug. 29, 1920, that I saw her alive on Aug. 28, 1920, and that death occurred, on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(Duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Coma

(Duration) — yrs. 1 mos. — ds.

(Signed) Edwin B. Fenby M. D.

8/30..., 1920 (Address) 1223 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem	9/1..., 1920
20-UNDERTAKER	ADDRESS
Chas R Wane & Son	118 W. Mt Royal Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46136 D46136 D46136

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 ST.; Glenwood Ave WARD 27th) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William b. Gault

(Residence in Baltimore: No. 827 Glenwood Ave St.: 70 yrs., ~~8~~ mos. ~~19~~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Dec 10, 1832 (Month) (Day) (Year)

7-AGE, 87 yrs. 8 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Boston Mass

PARENTS.

10-NAME OF FATHER, Rolf Gault

11-BIRTHPLACE OF FATHER (State or Country), Mass

12-MAIDEN NAME OF MOTHER Jane Howard

13-BIRTHPLACE OF MOTHER (State or Country), St. Johns N. B.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sallie A. Gault

(Address) 827 Glenwood ave

15-

Filed AUG 31 1920, 191.... Registrar.

ROBERT B KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 29, 1920 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Jan 26 1920, to Aug 29 1920, that I saw him alive on Aug 29 1920, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Cystitis.

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Enlarged Prostate

(Duration) yrs. mos. ds.

(Signed) Geo. H. McKay M. D.

Aug 30, 1920 (Address) 5835 Pimlico Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Farmer or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bald Cem | DATE OF BURIAL, 9/1/20

20-UNDERTAKER Chas. F. Evans & Son | ADDRESS Belmont Road

Spec.—8-24-14—M. & T.—2000 Bks.

L046137 HEALTH DEPARTMENT—CITY OF BALTIMORE L046137

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1114 Little Wilson ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Cain

(Residence in Baltimore: No. 1114 Little Wilson St.; unknown yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Blk

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug. (Month) 28th (Day), 1870 (Year)

7-AGE, 50 aged yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Easton, Md.

PARENTS.

10-NAME OF FATHER, Henry Cain

11-BIRTHPLACE OF FATHER (State or Country), Easton Md

12-MAIDEN NAME OF MOTHER Annie Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Easton Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Cain

(Address) 1114 Little Wilson St

15-

Filed AUG 31 1920, 191.....

ROBERT E. KRAUTH

Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 28th (Day); 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1st 1920, to Aug 28th 1920, that I saw h~~im~~alive on Aug 15th 1920, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

.....

.....

..... (Duration) 15 yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) Senile Heart & Asthenia

..... (Duration) ..... yrs. 6 mos. ..... ds.

(Signed) A. B. Glasscock M. D.

Aug. 28th, 1920 (Address) 1110 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Mt. Auburn

DATE OF BURIAL, Aug. 31, 191...

20-UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46138

D46138

D46138.

CERTIFICATE OF DEATH

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... St. 19 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Farrell

(a) RESIDENCE. No. 1345 Romney St., ... Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. M. Farrell

6 DATE OF BIRTH (month, day, and year) July 4 1870?

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
50?	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer D40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer dont know

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant (Address) Bay View Hospital Baltimore, Md.

15 Filed AUG 31 1920 Burial Permit Office Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 17, 1920 to Aug. 30, 1920 that I last saw h.. alive on Aug 29/ 4 10 A.M. 1920. and that death occurred, on the date stated above, at 4 10 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Dr Gregs findings

(Signed) H. Friedenwald M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Sept 2. 1920
20 UNDERTAKER James Dignan & Son	ADDRESS 1000 S Paca St

HOW IS very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46139

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46139

X 64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Overlea Ave ST.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia A. Burgess

(a) RESIDENCE. NO. Overlea Ave ST., WARD. Washington Lic.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Washington D C

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mrs Barbara Thompson

(Address) Overlea Ave

15 Filed AUG 31 1920, 19.. BUREAU OF VITAL STATISTICS Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 30th, 1920, to Aug 30th, 1920.

that I last saw h... alive on ..., 19..,

and that death occurred, on the date stated above, at 6 A. ...m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(duration) ... yrs. 7 mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Subsequent Paralysis

(Signed) Edward F. Benson, M. D.

, 19.. (Address) Overlea, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL ... 1920

20 UNDERTAKER J. Herring & Co

ADDRESS 2018 Eden

IMPORTANT: See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D46140

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46140

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home) February 26 (ST.) (WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christian Schreiver

(Residence in Baltimore: No. 3800 Fernwood Ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Jan 13, 1872 (Month) (Day) (Year)

7-AGE, 48 yrs. 7 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Chief Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) 031

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Henry Schreiver

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Christina Diese

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie J. Schreiver

(Address) 3800 Fernwood Ave

15-

Filed....., 191.....
Registrar.

ROBERT P. KRAUTER
SUPR. VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 30, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 11 1920, to Aug 30 1920, that I saw him alive on Aug 30 1920, and that death occurred, on the date stated above, at 1:45 P m.

The CAUSE OF DEATH* was as follows:

Cholecystitis Chronic
Cholelithiasis Chronic
Toxemia following operation
Contributory (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Russell C Swarts M. D.
, 191... (Address) Church Home Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 21 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem — DATE OF BURIAL, Sept 2, 1920

20-UNDERTAKER J Kerney & Co — ADDRESS 200 Park Ave

Spec. 6-9-19—H. P. Co.—1000 Bks.

D46141

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46141

CERTIFICATE OF DEATH.

135

3

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Med. & Chir. Hosp. St.; Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Elizabeth Burnam

(a) RESIDENCE. No. 120 S. Broadway St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas L. Burnam

6 DATE OF BIRTH (month, day, and year) Aug. 30, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER William C. Moore

11 BIRTHPLACE OF FATHER (city or town) St. Mary's Co. (State or country) Maryland.

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) Balto, (State or country) Maryland

14 Informant Chas L. Burnam (Address) 120 S. Broadway.

15 Filed AUG 31 1920, 19 ROBERT F. CARTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 24, 1920, to Aug. 30, 1920, that I last saw h.. alive on Aug 30, 1920, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows: Placenta Praevia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred B. Smith, M. D.

, 19 (Address) M. G. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 2 1920
20 UNDERTAKER Wm Cook	ADDRESS N & G Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 46142

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46142

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 S. First St Brooklyn 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy A Jones

(a) RESIDENCE. No. 121 S First ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George E Jones

6 DATE OF BIRTH (month, day, and year) Oct 24 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Moses Lent

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Caroline Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George E Jones
(Address) 121 S. First St

15 Filed AUG 31 1920 19 ROBERT A. LIGHTBOURN Registrar
Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1920, to Aug 31, 1920, that I last saw h... alive on ... 19..., and that death occurred, on the date stated above, at 3 40 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) X

(duration) X yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) H. Hunter, M. D.

, 19 (Address) 1340 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rosedale	Aug 31 1920

20 UNDERTAKER W. H. Cahoon & Son ADDRESS E Balto

Fr Frank Clarke's Clement

IMPORTANT: See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Sollie Weiner

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 46143

D 46143

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sollie Weiner

(a) RESIDENCE. No. 5825 Ellison ST., WARD. Phila, Pa

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred mos. 9 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2, 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Jacob Weiner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rebecca Granberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Hospital Record

(Address)

15 Filed ..., 19 ... Registrar

AUG 31 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1920.

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 19 20, to Aug 30, 19 20, that I last saw him alive on Aug 30, 19 20, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) 5 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at birth

Did an operation precede death? Yes Date of Aug 30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emil Holman, M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arbor Roudale	Aug 31 1920

20 UNDERTAKER: M. Shriner

ADDRESS 1627 E Baltimore St

Instructions on back of certificates. Please read carefully. Important. Use

Spec.—8-24-14—M. & T.—2000 Bks.

D46144 HEALTH DEPARTMENT—CITY OF BALTIMORE D46144

CERTIFICATE OF DEATH. 152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Ave + Edgewood St.; (or) 26 (WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Louise McClintock

(Residence in Baltimore: No. R Gardenville St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, 8 / 28, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 2 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓ nil
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Balto

PARENTS.

10-NAME OF FATHER, Wm McClintock

11-BIRTHPLACE OF FATHER (State or Country). Balto

12-MAIDEN NAME OF MOTHER Rose Koch

13-BIRTHPLACE OF MOTHER (State or Country). Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm L. McClintock

(Address) Franklin + Edgewood Ave

15- AUG 31 1920 ROBERT B HEATHER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 / 30, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8/28 1920, to 8/30 1920, that I saw h alive on 8/30 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cyanosis

Congenital

Syphilis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Gustave A Fiel M. D.

8/30, 1920 (Address) Catonsville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cemetery

DATE OF BURIAL. Aug 31, 1920

20-UNDERTAKER. Robt J Kerrigan Co

ADDRESS 1442 N Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046145

1046145

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jackson

(a) RESIDENCE. NO. 109 S. Broadway ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records.
(Address): New City Hospital.

15 Filed ..., 19... Registrar

AUG 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 29, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1920, to August 29, 1920, that I last saw her alive on August 29, 1920, and that death occurred, on the date stated above, at 8:40 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis with cerebral hemorrhage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed) V Bateman, M. D.

8/30/20 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	Aug 31 1920
20 UNDERTAKER	ADDRESS

THIS is very important. See instructions on back of certificates.

Spec.—5-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2046146

2046146

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. McCander

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Edward McCander

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Hospital Records, (Address) New City Hospital

15 Filed AUG 31 1920 ROBERT B KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 28 1920

17 I HEREBY CERTIFY, That I attended deceased from August 12, 1920. to August 28, 1920.

that I last saw h im alive on August 27, 1920.

and that death occurred, on the date stated above, at 5:00 A.m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed): E B Sherman, M. D.

8/30/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	Aug 31 1920
20 UNDERTAKER	ADDRESS

THIS IS VERY important. See instructions on back of certificates. Exact statement of OCCUPA-

at Morgue

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046147

CERTIFICATE OF DEATH.

50 1046147

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital, ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mick Feraslaw

(Residence in Baltimore: No. 711 Decolard St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Unk

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 24 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- AUG 31 1940, 191.....

JOHNS HOPKINS HOSPITAL Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 23, 1940 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Diabetes

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Jenkins M. D. (Coroner.)

8-26-40, 191.. (Address) 711 S. Decatur

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL | DATE OF BURIAL, Aug 31, 1940

20-UNDERTAKER | ADDRESS

Commissioner Health.

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

D.46148 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46148

CERTIFICATE OF DEATH.

REGISTERED No. C 6 119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1607 Orleans ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Hall

(Residence in Baltimore: No. 1607 Orleans St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ? (Month) ? (Day) 1874 (Year)

7-AGE, 46 yrs. ? mos. ? ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Housework

9-BIRTHPLACE, (State or Country), Raleigh, N.C.

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena Hall

(Address) 1607 Orleans St

15-

Filed ..... 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 28/8/1920, to 29/8/1920, that I saw h[illegible] alive on 29/8/1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Several months

(Duration) [illegible]

CONTRIBUTORY (Secondary) Anemia

Several days

(Duration) 2 yrs [illegible]

(Signed) Dr. Mayfield Bryd M. D.

30/8/, 1920 (Address) 425 N. Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodbury Conn. DATE OF BURIAL, Sept. 1, 1920

20-UNDERTAKER Wm J. Locke ADDRESS 1302 Jefferson st.

Robert F. Harrison, Registrar

AUG 31 1920

Burial Permit Clerk

M. Diagnosis. Mercy Hosp
ute hemorrhagic pancreatitis
morrhagic oedema lungs.
latation heart. Slight
rocele rt. side.

D.46149 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46149

CERTIFICATE OF DEATH. X 29

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 733 Lemmon (St.) 43 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Lucie C. Berry

(Residence in Baltimore: No.) 732 Lemmon St

St.; yrs., mos. 5 da.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH. June (Month) 17 (Day) 1873 (Year)

7-AGE. 47 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Milliner
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country) Raleigh N.C

PARENTS.

10-NAME OF FATHER. Ed. Berry

11-BIRTHPLACE OF FATHER (State or Country) Va

12-MAIDEN NAME OF MOTHER Frances Bullock

13-BIRTHPLACE OF MOTHER (State or Country). France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. C. Lanehan

(Address) Raleigh N C

15-

Filed ....., 191.....

Registrar

Robert F. Harrison,
AUG 1 1920
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, an[d] ...and that said deceased came to ...death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Disease
Heart

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) ..... M. D.
(Coroner.)

....., 191.. (Address) 3622 Roland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Raleigh N. C.

19-PLACE OF BURIAL, OR REMOVAL. Raleigh N.C

DATE OF BURIAL, Sept 1, 1920

20-UNDERTAKER HENRY W. JENKINS & SONS CO.

ADDRESS BALTIMORE, MD.

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.46150

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46150

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH Little Sisters of the Poor REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bridget Evasson

(Residence in Baltimore: No. Little Sisters of the Poor St.; 4 yrs., 5 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ? ....., 1850
(Month) (Day) (Year)

7-AGE, About 70 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Robert Evasson

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mrella Kehoe

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed ....., 191.....
Registrar.

AUG 31 1920 Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 30th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from No record 191..., to 191...,
that I saw her alive on Aug 27 1920,
and that death occurred, on the date stated above, at 11:30 a. m.
The CAUSE OF DEATH* was as follows:

.....
Arteria sclerosis
..... (Duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Cerebral apoplexy
..... (Duration) ... yrs. ... mos. ... ds.
(Signed) J. A. Warner, M. D.
Aug. 31, 1920 (Address) 1133 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death 4 yrs. 5 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Sept. 1, 1920

20-UNDERTAKER H. C. Wiedefeld — ADDRESS 914 Greenmount Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46151

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46151

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 1621 St Paul ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. B. Leslie

(a) RESIDENCE. No. 1601 St Paul ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leila J Leslie

6 DATE OF BIRTH (month, day, and year) Jan 24 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work conductor 193

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. O. R. R. Co

9 BIRTHPLACE (city or town) Annapolis Md
(State or country)

PARENTS

10 NAME OF FATHER Henry Le Leslie

11 BIRTHPLACE OF FATHER (city or town) Annapolis Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary [illegible]

13 BIRTHPLACE OF MOTHER (city or town) Annapolis Md
(State or country)

14 Informant Mrs Leila J Leslie
(Address) 1601 St Paul St

15 Filed ....., 19.....
Registrar

AUG 31 1920
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1920

17 I HEREBY CERTIFY, That I attended deceased from August 14, 1920, to Aug 30, 1920, that I last saw h[illegible] alive on Aug 30, 1920, and that death occurred, on the date stated above, at 10 P.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Died Home.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine test

(Signed) Joseph J Hennig, M. D.

, 19 (Address) 1812 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemt	Sept 1 1920

20 UNDERTAKER [illegible] ADDRESS [illegible] Baltimore

Sec. 6. Every undertaker shall keep a record of certificates. See instructions on back of certificates. Every undertaker shall keep a record of certificates. See instructions on back of certificates. OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bka.

D.46152 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46152

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 832 S Kenwood Ave. WARD 1)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Monek Moweish

(a) RESIDENCE. No. 832 S Kenwood Ave. WARD 1

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Mal

4 COLOR OR RACE Wht

5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 30 20

7 AGE Years Months Days If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Paul Mowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Borkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Paul Mowski

(Address) 832 S. Kenwood Ave

15 Filed AUG 31 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1920, to Aug 30, 1920, that I last saw h. alive on Aug 30, 1920 and that death occurred, on the date stated above, at 10 15 m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Allan J Ryerson M. D.

Aug 31 20 (Address) 861 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem

DATE OF BURIAL Aug 31 1920

20 UNDERTAKER Stephen J Fraikowski

ADDRESS 1000 S Kenwood Ave

(4) Instructions on back of certificates. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46153 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46153

CERTIFICATE OF DEATH.

89

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 S. Ann St.: 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabel S. Patten

(a) RESIDENCE. No. 213 S. Ann St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James S. Patten

6 DATE OF BIRTH (month, day, and year) Oct 24 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.Y. Conn. Connecticut

PARENTS

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (city or town) Conn. (State or country)

12 MAIDEN NAME OF MOTHER Sarah Bronck

13 BIRTHPLACE OF MOTHER (city or town) Conn. (State or country)

14 Informant Frederic N. Patten (Address) 710 McMechen St.

15 Filed AUG 31 1920 19 Robert F. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 19 20

17 I HEREBY CERTIFY, That I attended deceased from Aug-19- 1920, to Aug-20 1920, that I last saw her alive on Aug-20- 1920, and that death occurred, on the date stated above, at 9:30a m.

The CAUSE OF DEATH* was as follows:

acute Bronchitis

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) Neurasthenia of old age

(duration) 8 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) William F. Thomas, M. D.

Aug 21. 1920 (Address) 2016 Guilford ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Burlington N.J.	Sept 1 1920
20 UNDERTAKER H E Hughes	ADDRESS 17 N Broadway

Note—This is very important. See instructions on back of certificates. 5 OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

D.46154 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46154

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 W Clmt ST.; 23 WARD) REGISTERED NO. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Dreiling

(Resident in Baltimore: No. 102 W Clmt St.: 50 Yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH: Dec 25, 1845 (Month) (Day) (Year)

7-AGE, 74 yrs. 8 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Butcher D13
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Dreiling

(Address) 102 W Clement

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 29, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1, 1920, to Aug 29 1920, that I saw him alive on Aug 29 1920, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

Senile degeneration

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Senile degeneration

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. Lacy Lynn M. D.

Aug 31 1920 (Address) 1305 Mlbg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem	Sept 1, 1920
20-UNDERTAKER	ADDRESS 1039
J. Schuhmann & Son	Hanover St

Aug 1 1920 Robert P. Harrison, Burial Permit Clerk

Spec.—5-9-19—H. P. Co.—1000 Bks.

D.46155 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46155

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 Ashland ave ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosina Bonanno

(a) RESIDENCE. No. 924 Ashland ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 20-1920

7 AGE — Years	Months	Days	If LESS than 1 day, hrs. or min.
7	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Luigi Bonanno

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Filomena Lafazio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Luigi Bonanno (Address) 924 Ashland ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1920, to Aug 29, 1920, that I last saw her alive on Aug 29, 1920, and that death occurred, on the date stated above, at 6308 m.

The CAUSE OF DEATH* was as follows:

Mes Colitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Mary L Lunsford M. D.

, 19 (Address) 1028 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents Cemty	Sept 1920
20 UNDERTAKER	ADDRESS
George J Ruth	1738 Fayette ave

THIS is very important. See instructions on back of certificates.

AUG 31 1920

Burial Permit Clerk.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46156 D.46156

CERTIFICATE OF DEATH.

92 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 834 N. 36th St. WARD) 13

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Son Walbe

(Residence in Baltimore: No. 834 N. 36th St.)

Sta 25 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH. Nov. (Month) 16 (Day), 1844 (Year)

7-AGE. 35 yrs. 9 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Railroad 013
(b) General nature of industry, business, or establishment in which employed (or employer): Conductor

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: John F Walbe

11-BIRTHPLACE OF FATHER (State or Country): Pa

12-MAIDEN NAME OF MOTHER: Henrietta V Case

13-BIRTHPLACE OF MOTHER (State or Country): Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. V. Walbe

(Address) 834 N 36 St

15- Robert P. Harrison,

Filed AUG 31 1920, 191.... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 29 (Month) (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 27 1920, to Aug 29 1920, that I saw him alive on Aug 29 1920, and that death occurred, on the date stated above, at 9:0 p m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(Duration) yrs. mos. 2 ds.

(Signed) W. J. Gibney M. D.

Aug 31, 1920. (Address) 677 N Bond St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Pine Grove Cemetery	Sept. 1., 1920
20-UNDERTAKER	ADDRESS
E L Roy Stiffler	1249 North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46157 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46157

CERTIFICATE OF DEATH. X 105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST., 32d WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula B Jones

(a) RESIDENCE. NO. Cumberland Md ST., WARD. Marlinsburg

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15- 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
42	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 500

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Marlinsburg W. Va

PARENTS

10 NAME OF FATHER Joseph Jones

11 BIRTHPLACE OF FATHER (city or town) Marlinsburg (State or country) W. Va

12 MAIDEN NAME OF MOTHER Elgabeth Shump

13 BIRTHPLACE OF MOTHER (city or town) Marlinsburg (State or country) W. Va

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31 1920

17 I HEREBY CERTIFY, That I attended deceased from June 30 , 1920 , to Aug 31 , 1920 , that I last saw her alive on Aug. 30. , 1920 , and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Gastro-Entero-Colitis

(duration) 0 yrs. 2 mos. 0 ds.

CONTRIBUTORY (Secondary) Acute Mania-

(duration) 0 yrs. 3 mos. 0 ds.

18 Where was disease contrarted if not at place of death? Cumberland Md

Did an operation preeede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery , M. D.

, 19 (Address) Mt Hope Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Marlinsburg W. Va DATE OF BURIAL Sept 1 1920

20 UNDERTAKER STUART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

HON IS very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.46158 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46158

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH Womans Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Lafayette Ave + John ST.) 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Lamorelle

(Residence in Baltimore: No. Philadelphia Penna ST.; 0 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Aug 31, 1920 (Month) (Day) (Year)

7-AGE, 0 yrs. 0 mos. 0 ds. If LESS than 1 day, 1 hrs. or 55 Min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... 0 ..... nil
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Joseph Augustus Lamorelle

11-BIRTHPLACE OF FATHER (State or Country), Wayne, Pa.

12-MAIDEN NAME OF MOTHER Dorothy Myers

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. A. Lamorelle

(Address) Womans Hospital Md

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 31, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 31, 1920, to Aug 31, 1920, that I saw him alive on Aug 31, 1920, and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

Birth Injury

..... (Duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Helene Dorsch M. D.

....., 191... (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Philadelphia Pa	Sept 1, 1920
20-UNDERTAKER, STEWART & MOWEN COMPANY (MOWEN, Successor)	ADDRESS 108 W. NORTH AVE.

AUG 31 1920 Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46159 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46159

CERTIFICATE OF DEATH.

REGISTERED NO. 15-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3203 Piedmont Ave ST.; 15 WARD)

2-FULL NAME Margaret Lee Phillips

(a) RESIDENCE. NO. 3203 Piedmont Ave ST.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Carroll R. Phillips

6 DATE OF BIRTH (month, day, and year) May 2 - 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ivanties Maryland

PARENTS

10 NAME OF FATHER Chas. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Measures

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ivanties Md.

14 Informant Mrs Chas. Taylor
(Address) Ivanties Md.

15 Filed ..... 19 .....
Registrar

AUG 31 1920
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 24 1920, to Aug 31, 1920, that I last saw h alive on Aug 31, 1920, and that death occurred, on the date stated above, at 4.05 P. m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. Isolates

(Signed) Paul Brown M. D.

8/31. 19 20 (Address) 1837 Pa. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebron Md	Sept 1 19 20
20 UNDERTAKER	ADDRESS
Williams Coad &	502 E Nath

THIS IS very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D46160 HEALTH DEPARTMENT—CITY OF BALTIMORE D46160

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 Warren ST.; 21 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rev. Samuel A. Ringgold

(Residence in Baltimore: No. 920 Warren St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, March 15 1870
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
69 yrs. 5 mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Minister
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Kent Island Md.

PARENTS.

10-NAME OF FATHER, Peter Ringgold

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER, Elizabeth Rose

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah E. Ringgold

(Address) 920 Warren Ave.

15-

SEP 1-1920 ROBERT B KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 5, 1920, to August 29, 1920, that I saw h.... alive on August 29, 1920, and that death occurred, on the date stated above, at 2.40 P.M.

The CAUSE OF DEATH* was as follows: Dow

.....Cerebral Hemorrhage.....

.....

..... (Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Chatham M. D.

August 31, 1920 (Address) 20 E. Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn	Sept. 1, 1920
20-UNDERTAKER John H Scadin	ADDRESS 1913 Usher St

D46161 HEALTH DEPARTMENT--CITY OF BALTIMORE D 46161

CERTIFICATE OF DEATH

104

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. annapolis ave ST.: 25 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur J G Henderson

(Residence in Baltimore: No. annapolis ave St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: male

4-COLOR OR RACE: white

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: May (Month) 12, (Day) 1920 (Year)

7-AGE: 2 yrs. 3 mos. 19 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: Arthur J G Henderson

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Bertha Hale

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Bertha Henderson

(Address) Annapolis ave Md

15- SEP 1- 1920 ROBERT E KRAUTER

Filed ..... 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Aug (Month) 31, (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1, 1920 to Aug 31 1920, that I saw him alive on Aug 30, 1920 and that death occurred, on the date stated above, at 3 A m. The CAUSE OF DEATH* was as follows:

Summer Diarrhoea

(Duration) ..... yrs. ..... mos. 10 ds

Contributory (SECONDARY) same

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Geo L McCaffery M. D.

Aug 31, 1920 (Address) Maxwell Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Catonsville

19-PLACE OF BURIAL OR REMOVAL: Donated to Conrads Cemetary

DATE OF BURIAL: Sept 2 nd, 1920

20-UNDERTAKER: Knell & Son

ADDRESS: 1729 W Pratt st

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co. 1000 Blks.

D46162

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46162

CERTIFICATE OF DEATH.

138

1-PLACE OF DEATH St. Agnes Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Coppinger

(a) RESIDENCE. NO. 3020 Barley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Joseph Coppinger

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27 28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Tristman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bessie Trudy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Husband) Joseph Coppinger
(Address) 3020 Barley St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1920, to Aug 31, 1920, that I last saw her alive on Aug 31, 1920, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Childbirth

(duration) yrs. 9 mos. 0 ds.

CONTRIBUTORY (Secondary) Eclampsia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) E. P. Greenawalt, M. D.

. 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Sept 3 192-
20 UNDERTAKER	ADDRESS
Martin Fathey & Sons	827 N Eutaw St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46163

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46163

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Vincent Inf Asylum WARD)

2-FULL NAME Philip Babsinski

(a) RESIDENCE. No. St Vincent Asylum WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15/1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Philip Babsinski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Sr Innocentia
(Address) St Vincents Asylum

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1924

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1924 to Aug 27, 1924, that I last saw h[illegible] alive on Aug 27, 1924, and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Enterlitis
(Diarrhoea)
(duration) yrs. 1 mos. 27 ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas Holanbee, M. D.

(Aug. 30, 1924) (Address) 1 E of McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Sept 1, 192[illegible]

20 UNDERTAKER Walter Fahey & Sons ADDRESS 1827 N North Ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Berry

1046164 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046164

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1314 Mc; Bullshill ST. WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elsie L. Berry

(Residence in Baltimore: No. 1314 Mc Cullough St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Color

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. March 22, 1900
(Month) (Day) (Year)

7-AGE. ... yrs. 5 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) Ord

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER. Joseph Berry

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Irene Booker

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irene B. Berry

(Address) 1314 Mc Cullough

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug 30th, 1920
(Month) (Day), (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28th 1920 to Aug 30th 1920; that I saw h[illegible] alive on Aug 30th 1920, and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as followa:

Eclampsia

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Nephritis Chronic

(Duration) 2 yrs. ... mos. ... ds.

Signed A. Jos. Ellis M. D.

8/31, 1920 (Address) 324 Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery

DATE OF BURIAL, Sept. 1st, 1920

20-UNDERTAKER John H. Johnson

ADDRESS 1234 Eutaw St.

D46165

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D46165

1 PLACE OF DEATH

REGISTERED No. C 79

CITY OF BALTIMORE (No. 106 N Bond ST. 6 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Abraham A. Bass

(Residence in Baltimore: No. 106 N. Bond st St.; 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~SINGLE~~, MARRIED, ~~WIDOWED~~ OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Unknown (Month), 1 (Day), (Year)

7 AGE: 78 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Russia

PARENTS

10 NAME OF FATHER: Goetzie Bass

11 BIRTHPLACE OF FATHER (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) N. Bass

(Address) 106 N Bond st

15 SEP 1 - 1920 (191)

ROBERT F. LAUTER
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug (Month) 31 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1920. to. Aug 31 1920.
that I saw him alive on Aug 31 1920
and that death occurred, on the date stated above, at 7.30 p.m.
The CAUSE OF DEATH* was as follows:

Aortic Regurgitation
Arterio Sclerosis

(Duration) yrs. mos. ds

Contributory (SECONDARY) Cerebral Hemorrhage

(Duration) yrs. 1/2 hr mos. ds.

(Signed) Herman Seidel M. D.

Aug 31 1920 (Address) 2404 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 106 N Bond st

19 PLACE OF BURIAL OR REMOVAL: Hebrew Honing Pen — DATE OF BURIAL: Sept 1 1920

20 UNDERTAKER: A. Cohen — ADDRESS 1127 E Balto st

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 46166

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46166

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. U.S.P.H.S.Hospt #56, ST.; 24 WARD)

2-FULL NAME Douglas E. Wooden,

(Residence in Baltimore: No. U.S.P.H.S.Hospital #56, Balto. Md. St.; ....yrs.,....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	Colored	Single

6-DATE OF BIRTH, ... Unknown (Month) ....., 1 (Day) ..... (Year)

7-AGE,	If LESS than 1 day,
24 yrs. XXX Ms.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E.T. Rambeck

(Address) USPHSH#56, Fort McHenry.

15- ROBERT B KRAUTER

SEP 1 - 1920 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 29, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 13, 20 191.., to Aug. 29, 20 191.., that I saw him alive on Aug. 29, 20 191.., and that death occurred, on the date stated above, at 6:08 A m.

The CAUSE OF DEATH* was as follows:

Chronic pulmonary tuberculosis

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Hemorrhage

..... (Duration).....yrs.....mos.....ds.

(Signed) Thomas R. Payne M. D.

Aug. 29 20 191.. (Address) USPHS#56, Ft. McHenry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS). Md x x 16

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Unknown

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery — DATE OF BURIAL, Sept 1, 1920

20-UNDERTAKER S. Levin Bro — ADDRESS 1127 E Balto St

Sec. 3. Instructions on back of certificate.

W46167

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

120 W46167

1 PLACE OF DEATH

Registered No. C .....

CITY OF BALTIMORE (No. 521 E. 28th St. Ward 9)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Lucinda Carter

(Residence in Baltimore: No. 521 E. 28th St. St.: 39 yrs. \ mos. \ ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
F.	W.	Widow

6 DATE OF BIRTH Nov 1 (Month) 22 (Day) 1836 (Year)

7 AGE 83 yrs. 9 mos. 9 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) ooo

9 BIRTHPLACE (State or country) Md.

PARENTS

10 NAME OF FATHER Allen Warfield

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Ann Kelly

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Emma J. Gorsuch

(Address) 521 E. 28th St.

15 Filed SEP 1 - 1920 ROBERT F KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug (Month) 31 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to Aug 31, 1920

that I saw her alive on Aug 28, 1920

and that death occurred, on the date stated above, at 8-30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 3 mos. ds

Contributory (SECONDARY) Uremia

(Duration) yrs. mos. 3 ds.

(Signed) Geo. S. McKie Foley M. D.

Aug 31, 1920 (Address) Morley & Park Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL N. W. National Cemetery | DATE OF BURIAL Sept 2, 1920

20 UNDERTAKER Geo. J. Smith | ADDRESS 1600 N. Gay St.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46168

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46168

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1306 Williams St. ST.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Randolph H. Clarkson.

(a) RESIDENCE. No. 1306 Williams ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Katie Clarkson

6 DATE OF BIRTH (month, day, and year) Feb. 9th 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34 yrs -	6.	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work machinist gl

(b) General nature of industry, business, or establishment in which employed (or employer) tool making

(c) Name of employer Universal Machine Co

9 BIRTHPLACE (city or town) (State or country) Bridgeport Conn

PARENTS

10 NAME OF FATHER Charles Clarkson

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Katie Clarkson
(Address) Res 1306 Williams St

15 Filed SEP 1 - 1920 ROBERT F. LEAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31st 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1920, to Aug 31, 1920, that I last saw him alive on Aug 30, 1920, and that death occurred, on the date stated above, at 9:30 a m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) C. F. Buxton, M. D.

8/31. 1920 (Address) 301 E. Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	9/1 1920
20 UNDERTAKER	ADDRESS
Fisher & Sons	3 E. Eager St

9

TION is very important. See instructions on back of certificates.

...at it may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

D46169 HEALTH DEPARTMENT—CITY OF BALTIMORE D46169

36

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1521 Battery ave ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J Fitzpatrick

(a) RESIDENCE. NO. 1521 Battery ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work not any

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Thomas J Fitzpatrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Marie McGrath

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Thomas J Fitzpatrick
(Address) 1521 Battery ave

SEP 1 - 1920 ROBERT A. LAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1920.

17 I HEREBY CERTIFY, That I attended deceased from August 22nd 1920, to August 31, 1920, that I last saw him alive on August 30, 1920, and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

Rickets

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) D T Burston, M. D.

8/31. 1920 (Address) 301 East Lenox St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairview Cem	9/1 1920
20 UNDERTAKER	ADDRESS
J Edw Rowe	3 & Eighty

Spec.—6-9-19—H. P. Co.—1000 Bks.

046170

HEALTH DEPARTMENT—CITY OF BALTIMORE

046170

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 343-14 St. Highland ST.; 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman E Schaller

(a) RESIDENCE. NO. 343 14 Street ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced WIFE of (or) HUSBAND of Infant.

6 DATE OF BIRTH (month, day, and year) July 20 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant son

(b) General nature of industry, business, or establishment in which employed (or employer) Infant.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Norman G Schaller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant (Address) Norman G Schaller 343 14 St

15 Date SEP 1 - 1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1920, to Aug 30, 1920, that I last saw h alive on Aug 30th, 1920, and that death occurred, on the date stated above, at 11.25 A.M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Adam W ..... M. D.

(Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Maryland	Sept. 1920
20 UNDERTAKER	ADDRESS
Wendell Ruppert & Son	3/ Hanover

mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46171

HEALTH DEPARTMENT—CITY OF BALTIMORE

150

D46171

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 330 S. Bouldin St. ST.; 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Joseph Bayer Sr.

(a) RESIDENCE. NO. 330 S. Bouldin St., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 27-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jacob J. Bayer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Catherine Lotz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Jacob J. Bayer. 330 S. Bouldin St.

15 FILED SEP 1 - 1920 ROBERT E LEAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1920, to Aug. 31, 1920, that I last saw him alive on Aug. 31, 1920, and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease (Blue Baby)

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) N. B. Athey, M. D.

9/1, 1920 (Address) 2502 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Sept 1 1920
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe

TION is very important. See instructions on back of certificates.

ay be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

046172

HEALTH DEPARTMENT—CITY OF BALTIMORE

046172

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 N. Luzerne ave ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Snow

(a) RESIDENCE. NO. 816 N. Luzerne ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER John H. Snow

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Violet Schiller

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant John H. Snow (Address) 816 N. Luzerne ave

15 Filed SEP 1 - 1920 19 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 20

17

I HEREBY CERTIFY, That I attended deceased from Aug 1 19 20 to Aug 31 19 20 that I last saw him alive on Aug 31 19 20 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Obj. & Autop. Symp.

(Signed) Obj. & Autop. Symptoms M. D.

19 (Address) 130 E. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept 2 1920
20 UNDERTAKER	ADDRESS
Jos J. Kerr	102 N. Luzerne ave.

TION is very important. See instructions on back of certificates.

...l may be properly classified. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

D46173 HEALTH DEPARTMENT—CITY OF BALTIMORE D46173

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 19120 REGISTERED NO. C

CITY OF BALTIMORE: (No. 1028 E. Monument St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jones Marshall

(Residence in Baltimore: No. 1028 E. Monument St. 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male | 4-COLOR OR RACE. Color | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, unknown
(Month) (Day) (Year)

7-AGE 56 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Hostler

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary —

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE ~~BEST OF MY~~ KNOWLEDGE.

(Informant) Mrs. Ida Foster

(Address) 1028 E. Monument St.

15- Filed SEP 1 — 1920 191 ROBERT B KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Aug 30th, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1920 to Aug 30 1920 that I saw h— alive on August 7th 1920 and that death occurred, on the date stated above, 4 P. M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Ext. Chronic Cor.

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

(Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, White Chapel Co. and — DATE OF BURIAL, Sept 2, 1920.

20-UNDERTAKER Joseph A Farrell ADDRESS 1319 Division

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D46174 HEALTH DEPARTMENT—CITY OF BALTIMORE D46174

CERTIFICATE OF DEATH. 78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 650 Hanover St, St.: 22 Ward) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas L Smith

(a) RESIDENCE. No. 650 Hanover St St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 086

(b) General nature of industry, business, or establishment in which employed (or employer) no

(c) Name of employer no

9 BIRTHPLACE (city or town) (State or country) Hallville Md.

PARENTS

10 NAME OF FATHER [illegible] R. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER alice Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant alice Smith (Address) 650 Hanover St

SEP 1 - 1920 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 18, 1920, to Aug 29, 1920, that I last saw h alive on Aug 29, 1920, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Myocarditis Acute

(duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Dilitation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas F Lawrence, M. D.

Aug 30, 1920 (Address) 1504 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Sept 1, 1920

20 UNDERTAKER Chas & Geo H Hoofert ADDRESS 106 W Conway

TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046175 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046175

CERTIFICATE OF DEATH. 104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 327 D Parish ST.: 19 WARD)

2-FULL NAME Thodora Carr

(a) RESIDENCE. NO. 327 D Parish ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 29/19

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	9	—	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) — do

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harry P. Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Aberdeen Md

12 MAIDEN NAME OF MOTHER Mary E. Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mary E. Carr 327 D Parrish st

15 Date SEP 1 - 1920 ROBERT B. [illegible] Registrar

Burial Permit Oferd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-30 1920

17 I HEREBY CERTIFY, That I attended deceased from August 10, 1920, to August 30, 1920

that I last saw h— alive on August 30, 1920

and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Sigfred D Rau, M. D.

Aug 31, 1920 (Address) 1727 Columbus

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	Sept 1st 1920
20 UNDERTAKER R. Jones	ADDRESS 207 S Stre[illegible]

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46176

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46176

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital (St.) 4 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Henson

(a) RESIDENCE. No. 717 Sarah Ann St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Wm. Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Martha Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records
(Address) M.T.H.

Filed SEP 1 - 1920 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 3, 1920, to Aug. 29, 1920, that I last saw her alive on Aug. 29, 1920, and that death occurred, on the date stated above, at 10.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed) L J Aigrey, M. D.

8-30-20, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion, Cem. DATE OF BURIAL: Sept 1 1920

20 UNDERTAKER: Samuel Kennedy ADDRESS: 578 Biddle St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46177

CERTIFICATE OF DEATH.

D 46177

REGISTERED NO. 15-120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital (St.) 15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME E. Stephen Lewis.

(a) RESIDENCE No. 2119 Lyndhurst Ave. St., Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 5 mos. 5 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE Sydney V. Lewis 1853

6 DATE OF BIRTH (month, day, and year) April 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	5	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer) Mutual Life
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wm Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Sarah Redden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Chas S. Lewis
(Address) 211 Lyndhurst St

Filed SEP 1 - 1920 ROBERT B. BEAUTER Registrar
Burial Permit Office

TION is very important. See instructions on back of certificates. ...ck of OCCUPA-

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 31 1920

17 I HEREBY CERTIFY, That I attended deceased from August 24, 1920, to August 31, 1920, that I last saw h[illegible] alive on August 31, 1920, and that death occurred, on the date stated above, at 8.45 A m.

The CAUSE OF DEATH* was as follows:

Impermeable Stricture of Urethra. over

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Complete suppression of urine following operation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At residence.

Did an operation precede death? Yes. Date of August 24, 26, 30
No.

Was there an autopsy?

What test confirmed diagnosis? Physical Examination & Operation

(Signed) E. Wilbur Stewart, M. D.

8/31, 1920 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept 2nd 1920

20 UNDERTAKER ADDRESS
R B Kippert 2236 Frederick Ave

Inf of Richard & Louisa Hinton

D46178

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46178

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1122 Low. ST.; 5 WARD) REGISTERED NO. C 152

2-FULL NAME Not. Named

(Residence in Baltimore: No. 1122 Low St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.)
M	C	Single

6-DATE OF BIRTH, Aug (Month) 31 (Day) 1920 (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, ...hrs. or 6 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

PARENTS.

9-BIRTHPLACE, (State or Country), Balto Md.

10-NAME OF FATHER, Richard Hinton

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER, Louisa Hollingsworth

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louisa Hinton

(Address) 1122 Low St

15- Filed SEP 1 - 1920, 191.... ROBERT E KRAUTER Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 31 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia Neon.

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Epilepsine

(Duration) yrs. mos. 1 ds.

(Signed) F. C. Glade M. D. (Coroner)

9/1/20 1921 (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel	Aug 1, 1920
20-UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046179 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046179

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 W. Balto St. St.: 18 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lee

(a) RESIDENCE. No. 830 N. Balto St. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 2nd 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (old)

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER John Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md.

12 MAIDEN NAME OF MOTHER Mildred Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Martha Hays

(Address) Lawrence Ave

Filed SEP 1 - 1920 ROBERT E KRAUTER Registrar

Burial Permit 01871

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 31, 1920, to Aug 31, 1920, that I last saw him alive on Aug 31, 1920, and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Rhachitis (Rickets) & marasmus

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at birth

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) John D Bubert M. D.

Aug 3, 1920 (Address) 4884 Park Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Sept 1 1920

20 UNDERTAKER Geo B Cook — ADDRESS 1033 W Balto

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46180 ✓ 9 79 D46180

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2043-31st ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J Morris

(Residence in Baltimore: No. 2043 31st St.; 40 yrs.,.. mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb (Month) 15 (Day), 1857 (Year)

7-AGE, 63 yrs. 6 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Kent Co

PARENTS.

10-NAME OF FATHER, Edward Bradley

11-BIRTHPLACE OF FATHER (State or Country), Kent Co

12-MAIDEN NAME OF MOTHER Eliza J Hepburn

13-BIRTHPLACE OF MOTHER (State or Country), Kent Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B P Morris

(Address) 2043 E 31st St

15- [illegible]

Filed SEP 1 1920, 191.. [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 30th (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from July 3 1919, to Aug 30 1920, that I saw her alive on Aug 30th 1920, and that death occurred, on the date stated above, at 5 30 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) .... yrs. 1 mos. .... ds.

CONTRIBUTORY (Secondary) R H Hamilton

(Duration) .... yrs. .... mos. .... ds.

(Signed) H J B Kelly M. D.

Aug 31st, 1920 (Address) 120 E Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Sept 1st, 1920

20-UNDERTAKER E J Fanning & Son

ADDRESS 1938 E Lafayette Ave

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46181

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64

D46181

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 W. Kennetta ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Harold Scarlett

(a) RESIDENCE. No. 121 W. Kennetta ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	40	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kingston Jamaica B.W.I.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) B.W.I

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) B.W.I.

14 Informant May Johnson X
(Address) 121 W. Mennett X

15 Filed SEP 1 - 1920 19 ROBERT P. LAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 23. 1920. to Aug 30. 1920. that I last saw him alive on Aug 30. 1920. and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arterial Hypertension

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? I do not know

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Carroll, M. D.

1920 (Address) 140 W. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Sept 1 1920

20 UNDERTAKER ADDRESS

R. L. Parham 647 W Lexington

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. Answers must be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

D46182

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46182

CERTIFICATE OF DEATH.

81

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2858 N Fremont St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Boyd

(a) RESIDENCE. No. 2858 N Fremont ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosina Boyd

6 DATE OF BIRTH (month, day, and year): Nov 3 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Marble Cutter

(b) General nature of industry, business, or establishment in which employed (or employer): Marble Cutter

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Jno Boyd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emma Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Carroll Boyd (Address) 2858 W. Chanval St

15 Filed SEP 1 - 1920 ROBERT F. FOSTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1920, to Aug 31, 1920, that I last saw h alive on Aug 30, 1920, and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows: Uraemia

Cardiac Asthenia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis Senile

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Autopsy

(Signed) Samuel Hahn, M. D.

19 (Address) 2021 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Victor Family Burying Ground near Woodlawn	Sept 2 1920

20 UNDERTAKER: Wm. Cook — ADDRESS: 502 E. North Ave

PHYSICIANS should state DISEASE CAUSING DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46183

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46183

152

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marjorie ~~Hackney~~ Luttrell

(a) RESIDENCE. No. 3817 Ashburton ave ~~University Hospital~~ WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): ~~Single~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 28-1920

7 AGE — Years: ~ Months: ~ Days: 4 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~

(b) General nature of industry, business, or establishment in which employed (or employer): ~

(c) Name of employer: ~

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: J. J. Luttrell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va Northumberland Co.

12 MAIDEN NAME OF MOTHER: Sudie Hackney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wilson N. C.

14 Informant: J. J. Luttrell

(Address): 3817 Ashburton st

15 Filed SEP 1 - 1920 19.. ROBERT B KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1st 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 28th, 1920, to Sept 1st, 1920, that I last saw her alive on Aug 31st, 1920, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Cortical (Cerebral) Hemorrhage

(duration) ~ yrs. ~ mos. 4 ds.

CONTRIBUTORY (Secondary) Pressure during birth

(duration) ~ yrs. ~ mos. ~ ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? Yes Date of Forceps Delv.

Was there an autopsy? No

What test confirmed diagnosis? ~

(Signed) L. E. Neale M. D.

. 19 (Address) 822 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Sept 2 1920

20 UNDERTAKER: H M Routzon

ADDRESS 2258 W Saratoga

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46184 HEALTH DEPARTMENT—CITY OF BALTIMORE D46184

CERTIFICATE OF DEATH. 37

1-PLACE OF DEATH Boylan Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Denmark

(a) RESIDENCE. No. 529 Fawn ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jessie Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Laura S. Denmark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Boylan Hospital
(Address) Baltimore, Md.

15 Filed SEP 1 - 1920 ROBERT B. LAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31, 1920

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1920, to Aug. 31, 1920, that I last saw h alive on Aug 30, 1920, and that death occurred, on the date stated above, at 8 45 A.M.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Insane)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis Cystostomy.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? — Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological & Phy

(Signed) N. Hedsmith M. D.

8/31/ 20 (Address) Boylan Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 2 1920
20 UNDERTAKER	ADDRESS
Wm. H. Cline & Son	1701 Madison

TION is very important. See instructions on back of ... ay be properly classified. Exact statement of OCCUPA- ... ck of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46185 ~~D.46185~~ D.46185

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Jos. Hosp. (St.:) 9 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mad Satterfield

(a) RESIDENCE. No. 538 E. Preston St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wh.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wilmer Satterfield

6 DATE OF BIRTH (month, day, and year): Unknown 1897

7 AGE: Years 23 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. wife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Dawson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Nellie

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Mrs. Nellie Dawson

(Address) 914 E. Chase St.

Filed SEP 1 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 30 19 20

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 19 20, to Aug 30, 19 20,

that I last saw h. alive on Aug 30, 19 20,

and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Post partum Hemorrhage

Patient died 1 hr after delivery — from shock.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Post partum Hemorrhage,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 2631 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL: Sept 1 19 20

20 UNDERTAKER: H. C. Wiedefeld — ADDRESS: 914 Greenmt Av

TION is very important. See instructions on back of certificates. ...ary be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46186 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46186

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1000 Forrest Place ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Leland

(a) RESIDENCE. No. 1000 Forrest Place ST., ..WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5-0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Leland

6 DATE OF BIRTH (month, day, and year): Sept 3-1838

7 AGE: Years 82 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Thomas Leland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Norton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Dr Fenton

15 Filed SEP 1 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1920, to Aug 31, 1920, that I last saw him alive on Aug 31, 1920, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary): arteriosclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1000 Forrest St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

9/1/1920 (Address) 2004 Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem | DATE OF BURIAL: Sep 2 1920

20 UNDERTAKER: H. B. Wiedefeld | ADDRESS: 914 Greenmount ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Should state TION is very important. See instructions on back of certificates. exact statement of OCCUPA-

D.46187 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46187

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 130 S. Exeter ST.: 3 WARD) REGISTERED No. C 64

2-FULL NAME Katie Rosen (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 130 S. Exeter St.; 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Louis Edlowitch

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam Rosen

(Address) 130 S Exeter St

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 1, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Ripley Walker M. D.
(Coroner)

Sept 1, 1920 (Address) 1800 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Sept 2	Sept 2 1920
20-UNDERTAKER M. Levinson	ADDRESS 1127 E Balto St

Important. See instructions on back of certificate.

Spmc.—6-9-19—H. P. Co.—1000 Bks.

D.46188 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46188

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2443 Etting ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Jones

(a) RESIDENCE. No. 2443 Etting ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sylvanus

6 DATE OF BIRTH (month, day, and year) Jan 27, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
		7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Alex Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Blanche Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Loretta Jones (Address) 2443 Etting St

15 Filed SEP 1 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1920, to Aug 31, 1920, that I last saw h.. alive on Aug 31, 1920, and that death occurred, on the date stated above, at 8.45 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. William Frey, M. D.

8/31, 1920 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 2 1920
20 UNDERTAKER	ADDRESS
Hamme & Wright	1364 W Camey

IMPORTANT is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.46189 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.46189

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 4 1

CITY OF BALTIMORE: (No. New City Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Cornish

(a) RESIDENCE. No. 624 Ruboy or Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Taylor's Island, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed SEP 1- 1920, 19 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 31, 1920

17 I HEREBY CERTIFY, That I attended deceased from August 28, 1920, to August 31 1920, that I last saw him alive on August 31, 1920, and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Bacteriological studies still in progress

(Signed) J. Bosserman M. D.

9/1/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Taylors Island Dor. Co.	2nd Sept. 2 1920
20 UNDERTAKER	ADDRESS
Mrs George H Hooper	Sept 2 1920

TION is very important. See instructions on back of certificates.

(Kogelschatz)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46190 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46190

CERTIFICATE OF DEATH. -130

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Franklin Sq. Hospital 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lena Kogelschaltz

(a) RESIDENCE. No. 2202 Pressbury ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Kogelschaltz

6 DATE OF BIRTH (month, day, and year) Jan 24-1890

7 AGE 30	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Chas Gutlaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Laura Himbeemes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Harry L. Kogelschaltz

(Address) 2202 Pressbury St

15 Filed SEP 1- 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug. 31, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1920, to aug. 31, 1920, that I last saw h-er alive on aug 31, 1920, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Peritonitis due to Pelvic abscess, which ruptured according to Hist[ory] at St. Hospital (duration) — yrs. 1 mos. 24 ds.

CONTRIBUTORY (Secondary) Septicemia (Gen)

(durstion) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of July 7, 1920

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Lyman J. Abbott, M. D.

, 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Martinsburg West Va	Sept 2 1920
20 UNDERTAKER	ADDRESS
Chas E. Evans & Son	118 W. Mt. Royal Ave

TION is very important. See instructions on back of certificates. OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 46191 ✓ D. 46191

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1627 N. Spring ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter E. Wirth

(a) RESIDENCE. No. 1627 N. Spring ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year) Jan 4, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	7	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Yard Clerk Bolton Depot.
(b) General natore of industry, business, or establishment in which employed (or employer): Penn. R.R.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER James H. Wirth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER Rebecka Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant (Address) James H. Wirth 1627 Spring St

SEP 3 - 1920 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 19 1920, to Aug 31, 1920, that I last saw him alive on Aug 31, 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Uremia, Interstitial Nephritis
Hematuria & Cystitis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis (duration) 1 yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinary Analysis

(Signed) C. R. Carman, M. D.

19 (Address) 1701 Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 4 1920
20 UNDERTAKER	ADDRESS
Elmer W. Conklin	924 E Eager St

FILED

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

246192 HEALTH DEPARTMENT—CITY OF BALTIMORE D 46192

CERTIFICATE OF DEATH. 81

1-PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No 822 S. Robinson St.; 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jas Knight

(a) RESIDENCE. No. 822 S. Robinson St., 1 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachael Virginia Knight

6 DATE OF BIRTH (month, day, and year) July 13 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 206

(b) General nature of industry, business, or establishment in which employed (or employer) Blacksmith

(c) Name of employer 17 yrs ago

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER — Moore

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mary E. Knight
(Address) 822 S. Robinson

15 Filed SEP 2 1920 Robert B Krauter
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1920, to Aug 31, 1920, that I last saw h[illegible] alive on Aug 31, 1920, and that death occurred, on the date stated above, at 10.50 a.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilated of heart

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. J. M'Avoy, M. D.

8/31, 1920 (Address) 836 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel — DATE OF BURIAL Sept 3 1920

20 UNDERTAKER William Cook — ADDRESS 506 E Monument

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Q 46193 — 15 — Q 46193

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. ..... ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Marshall

(a) RESIDENCE. NO. 358 W Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. — ds. How long in U. S., if of foreign birth? 0 yrs. — mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Aug 27 1920

7 AGE	Years	Months	Days	If LESS than 1 day, 0 hrs. or ..... min.
	0	0	5	

8 OCCUPATION OF DEAD

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Doctor Simpson

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Carrie Marshall

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant R. B. Johnston
(Address)

15 Filed SEP 2 - 1920, 19.. ROBERT B. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 19 20

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 19 20, to Aug 31, 19 20,

that I last saw h[illegible] alive on Aug 31, 19 20,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic Disease of newborn

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Guy N. Cromwell, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Sept 2 1920
20 UNDERTAKER Samuel D. Hemsley	ADDRESS 578 N Eddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46194 D46194

CERTIFICATE OF DEATH.

1042

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 McDonough ST.: 8 WARD)

2-FULL NAME Charles E Schissler

(a) RESIDENCE. No. 1109 McDonough ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 11th 1914

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Harry Schissler

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Florence L Hall

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Harry Schissler
(Address) 1109 McDonough st

15 Filed SEP 2 - 1920 19.... ROBERT F. [illegible] Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-1-1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 26, 1920, to Sept 1, 1920, that I last saw him alive on Aug 31, 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W Ruth M. D.

9/1, 1920 (Address) 1101 Eway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 2nd 1920
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

046195 HEALTH DEPARTMENT—CITY OF BALTIMORE 046195

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 W. Saratoga ST. 19 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Howard

(Residence in Baltimore: No. 1610 W. Saratoga St.; 3 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. C

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED.~~ (*Write* the word.) Widow

6-DATE OF BIRTH. May 7, 1875 (Month) (Day) (Year)

7-AGE. 45 yrs. 3 mos. 7 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Cook
(b) General nature of industry, business, or establishment in which employed (or employer). Domestic

9-BIRTHPLACE, (State or Country). Calvert Co. Md

PARENTS.

10-NAME OF FATHER. General Chase

11-BIRTHPLACE OF FATHER (State or Country). Calvert Co. Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kathryn Chase

(Address) 1610 W. Saratoga St.

15- SEP 2 - 1920

Filed ....., 191.....

ROBERT E KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Aug 30, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 5 1920, to Aug 30 1920, that I saw h.er alive on Aug 30 1920, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ....yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. Mac Rae M. D.

Aug 31 1920 (Address) 73 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem. DATE OF BURIAL. Sept 2, 1920

20-UNDERTAKER John H. Toadvine ADDRESS 142 Wolfe St

Imprint: See instructions on back of certificate.

Remarks

No other abnormal condition known.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis.*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Bks.

L046196

HEALTH DEPARTMENT—CITY OF BALTIMORE

L046196

CERTIFICATE OF DEATH.

50

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 E. Chase St.; 10 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John E. Peat

(Residence in Baltimore: No. 711 E. Chase St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July 9, 1869
(Month) (Day) (Year)

7-AGE, 51 yrs. 1 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): Stone

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Wm Peat.

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Mary V. Peterson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret C. Peat

(Address) 711 E. Chase

15- Filed SEP 2 - 1920 191.. ROBERT J. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 31 20, 191...
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept. 1918, to Aug 31 1920, that I saw h[illegible] alive on Aug 30 1920, and that death occurred, on the date stated above, at 12 30 Am.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(Duration) yrs. 2 mos. ds.

(Signed) Kenneth Levy M. D.

8/31/20, 191... (Address) 1207 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, 9/3/20 191...

20-UNDERTAKER H. C. Wedefeld ADDRESS 914 Gunnard

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46197 HEALTH DEPARTMENT—CITY OF BALTIMORE D46197

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 W. Fayette St ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Goldberg

(a) RESIDENCE. No. 1013 W. Fayette St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sprinza Goldberg

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Osher Goldberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Lewis 1411 E. Baltimore St

15 Filed SEP 2 - 1920 . 19 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-1 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 20 , 1920 , to Sept 1st , 1920 , that I last saw h[illegible] alive on Aug 20 , 1920 , and that death occurred, on the date stated above, at 9 am m.

The CAUSE OF DEATH* was as follows:

Aortic dat Mitral Regurg.

Cardiac Hypertrophy - Chronic Nephritis

(duration) Medium yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) I. Ries , M. D.

Sept. , 1920 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Rose dale	Sept 2 1920

20 UNDERTAKER ADDRESS

Jack Lewis 1411 E. Balto

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D46198 — 120 D46198

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 N Strieker ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wyndham Albert Sullivan

(a) RESIDENCE. NO. 415 N Strieker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Carrie Sullivan

6 DATE OF BIRTH (month, day, and year) July 4 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Silversmith

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer Self

9 BIRTHPLACE (city or town) Easton
(State or country) Penna

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Carrie Sullivan
(Address) 415 N Strieker

15 Filed SEP 2 - 1920 ROBERT E LEAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1 1920

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1920, to Aug. 31, 1920, that I last saw him alive on Aug 31, 1920, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis.

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Indefinite (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? urinary analysis.

(Signed) H. H. Arthur, M. D.

19 (Address) 1426 W Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 3 1920
20 UNDERTAKER	ADDRESS
M. J. Sauer & Son	Monroe

Note.—Very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1046199 1046199 80

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2824 Hayford ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur b. Davis

(a) RESIDENCE. NO. 2824 Hanford Ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Fountain.

6 DATE OF BIRTH (month, day, and year) Aug 6. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	—	25	

8 OCCUPATION OF DECEASED Night Watchman

(a) Trade, profession or particular kind of work Bensch Dep Store

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Benjamin Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lotte Kuss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Florence Davis (Address) 2824 Hayford ave

15 Filed SEP 2 - 1920 ROBERT F KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1920

17 I HEREBY CERTIFY, That I attended deceased from May 4 . 1920 . to Sep 1st . 1920 . that I last saw h[illegible] alive on Sep 1st . 1920 . and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical data only

(Signed) Wm T. Watson, M. D.

, 19 (Address) 2178 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Sept 2 1920

20 UNDERTAKER J Herwig & Co

ADDRESS 2008 Eutaw

TION is very important. See instructions on b[illegible] may be properly classified. Exact statement of OCCUPA- g on back of certificates.

D46200 HEALTH DEPARTMENT—CITY OF BALTIMORE D46200

CERTIFICATE OF DEATH.

175-004

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Union Protestant Hospital WARD) 15

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H Bauer

(Residence in Baltimore: No. The Rockwell, Park Heights Ave St.; 68 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	Wid

6-DATE OF BIRTH, May (Month) 25 (Day), 1853 (Year)

7-AGE, 68 yrs. 3 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... Gas Co

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Bauer

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Eliza Felking

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leonora E Bauer

(Address) 1227 E Preston

15- SEP 2 - 1920 ROBERT F KRAUTER

Filed....., 191..... Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 31 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....inquest.... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....inquest.... (Inquest, autopsy or inquiry.) find that said deceased came to ....his.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull
Struck by street car (accidental)
(Duration).....yrs.....mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia
(Duration).....yrs.....mos. 1 ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)

September 1, 1920 (Address) 2802 E Monument Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. 5 ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....
Accident

Former or usual residence The Rockwell Park Heights Ave

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery — DATE OF BURIAL, Sep 3, 1920

20-UNDERTAKER John O. Mitchell — ADDRESS 701 W. Fayette

IMPORTANT.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D46201 HEALTH DEPARTMENT—CITY OF BALTIMORE D46201

CERTIFICATE OF DEATH.

172

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital St. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Wm H Brooks

(Residence in Baltimore: No. 4007 Frederick Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March 31st, 1881
(Month) (Day) (Year)

7-AGE, 39 yrs. 5 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henry Brooks

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Magda Brooks

(Address) 4007 Frederick Ave

15- SEP 2 - 1920 ROBERT B LEAUTER
Filed....., 191.....
(Clerk)
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 1, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pneumonia Lobar
Proof
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

Signed J R Dailey M. D.
(Coroner)
9-2, 1920 (Address) 4 E Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery
DATE OF BURIAL, Sept 4, 1920

20-UNDERTAKER H B Kappel
ADDRESS 2316 Fred'k Ave

IMPORTANT: PHYSICIANS should state DISEASE CAUSING DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D46202 HEALTH DEPARTMENT—CITY OF BALTIMORE D46202

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 North Carey ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Henry Daiger

(a) RESIDENCE. No. 608 North Carey Street ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 7 mos. 13 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow Charles Henry Daiger

6 DATE OF BIRTH (month, day, and year) Jan 19 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Reese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eng.

12 MAIDEN NAME OF MOTHER Amelia M. Debo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eng.

14 Informant Matt L. Daiger
(Address) 709 W Fayette St

15 Filed SEP 2 - 1920 16 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1920, to Sept 1, 1920, that I last saw h[illegible] alive on Sept 1, 1920, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harold M Hamman, M. D.

, 19 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Sept 4 1920
20 UNDERTAKER George J. Smith	ADDRESS 1000 W Fayette St

TION is very important. See instructions on back of certificates. It may be properly classified. Exact statement of OCCUPA-

Spec.—6-3-19—H. P. Co.—1000 Bks.

1146203 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓1146203

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. 143

CITY OF BALTIMORE: (No.) Md. General Hospital (St.) 15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert K. Cummins

(a) RESIDENCE. No. 3406 Carlisle Ave St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret P. Cummins

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	9	5	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Assistant Treasurer of

(b) General nature of industry, business, or establishment in which employed (or employer) Consolidated Engineering Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Robert P. Cummins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Josephine Keys

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant (Address) Robert P. Cummins 2411 Garrison Ave.

15 Filed SEP 2 - 1920 16 ROBERT R KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15, 1920, to Sept. 1, 1920, that I last saw h[illegible] alive on Sept. 1, 1920, and that death occurred, on the date stated above, at 10. P. m.

The CAUSE OF DEATH* was as follows:

Carbuncle on posterior part of neck -

(duration) yrs. 1 mo. ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? 3406 Carlisle Ave.

Did an operation precede death? Yes Date of 8/14/20

Was there an autopsy? No -

What test confirmed diagnosis? Laboratory

(Signed) Philibert Artigiani M. D.

9/1/1920 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept. 4 1920
20 UNDERTAKER	ADDRESS
Jos B Cook	1003 W Balto

IMPORTANT. See instructions on back of certificates.

D 46204

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46204

CERTIFICATE OF DEATH.

80

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 238 N Bruce ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Noll

(Residence in Baltimore: No. 238 N Bruce St.; yrs., mos. ds.) Life

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Married

6-DATE OF BIRTH, Aug 15, 1862
(Month) (Day) (Year)

7-AGE, 58 yrs. 0 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House maid
(b) General nature of industry, business, or establishment in which employed (or employer)..... Private family

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Gray

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lonia Wallace

(Address) 210 N Bruce St

15-

Filed SEP 2 - 1920, 191.....

ROBERT E. KRAUTH
Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ruptures Coronary Artery (Duration) yrs. mos. ds. Sudden

(Signed) James W Preston M. D.
(Coroner.)

Aug 30 1920 (Address) 709 E Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	Sept 2., 1920

20-UNDERTAKER	ADDRESS
Clement Hall	1945 Pennsylvania

important. See instructions on back of certificate.

PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46205 HEALTH DEPARTMENT—CITY OF BALTIMORE D-46205

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 Sarah Ann St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Benjamin Jones

(a) RESIDENCE. No. 825 Sarah Ann St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Ida Jones

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE: Years 36 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Undertaker

(b) General nature of industry, business, or establishment in which employed (or employer): 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Alonzo Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Mary Jones 825 Sarah Ann st

15 Filed SEP 2 - 1920 ROBERT P. LAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/31/1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1920, to Aug 31, 1920, that I last saw him alive on Aug 30, 1920, and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Valvulitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Epithelioma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Result of Injury received extended A

Did an operation precede death? Yes Date 8/30/20

Was there an autopsy? Yes

What test confirmed diagnosis? Gen. Path. Lab. Balto Co. Gen. Hosp.

(Signed) W. H. Neville M. D.

8/31, 1920 (Address) 767 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Sept 5 1920

20 UNDERTAKER: Mrs Robt B Elliott — ADDRESS: 1725 Eastend Ave

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

1046206

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046206

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 Jackson, ST.: 24th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Smith.

(a) RESIDENCE. No. 1814 Jackson, ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5/0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 6. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Alexander Smith.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Elizbeth Manley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Elizbeth Anthony
(Address) 1814 Jackson

15 Filed SEP 2 - 1920 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1920, to Sept 1, 1920, that I last saw him alive on Aug. 31, 1920, and that death occurred, on the date stated above, at 1. 1. m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. T. Seabury, M. D.

(Address) 638 East Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	9/2 1920
20 UNDERTAKER	ADDRESS
Mary E. Gordon	1728 Ash

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46207

HEALTH DEPARTMENT—CITY OF BALTIMORE

104

D46207

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 Main Ave ST.: Arlington 28 WARD)

2-FULL NAME Charles E Crandell

(a) RESIDENCE. No. 4 Main Ave WARD Arlington

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Wm D Connelly

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Blanche F Wyzenski

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Emma C Smith
(Address) 5213 Denmead ave

15 Filed SEP. 2 - 1920 ROBERT I KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 27 1920, to Sept 1, 1920, that I last saw h alive on Sept 1, 1920, and that death occurred, on the date stated above, at 12 25 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Milk Infection

(duration) yrs. mos. 6 ds.

18 Where was disease contracted? At Home
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) W R Dolch, M. D.

, 19 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Sept 3 1920

20 UNDERTAKER Wm Lach ADDRESS 532 E North Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

L46208 L46208 104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 W Camden St. ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Melvin Kolitas.

(a) RESIDENCE. NO. 416 W Camden St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 19 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	✓	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) nil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Kolitas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Marie Stahl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant William Kolitas (Address) 416 W Camden St

15 FILED SEP 2-1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/1/20 19

17 I HEREBY CERTIFY, That I attended deceased from August 20 19 20 to August 31 20 19

that I last saw h im alive on August 31/20 19

and that death occurred, on the date stated above, at 4/31PM. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis.

(duration) 10 yrs. Days mos. ds.

CONTRIBUTORY (Secondary) Mal nutritipn

(duration) 10 Days. yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery DATE OF BURIAL: Sept 2. 19 20

20 UNDERTAKER: Jos. Jourdens Son ADDRESS: 217 S Bca St

TION is very important. See instructions on back of certificates. ...may be properly classified. Exact statement of OCCUPA-

Mamie Samuels.

D46209 HEALTH DEPARTMENT—CITY OF BALTIMORE D46209

CERTIFICATE OF DEATH.

170

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1534 E Fayette St. WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Samuel

(Residence in Baltimore: No. 1534 E Fayette St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Jan. 5, 1894
(Month) (Day) (Year)

7-AGE, 26 yrs. 7 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): 07

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Wm. H. Ridgley.

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Mary Jemison

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Martin

(Address) 1534 E. Fayette St.

15- SEP 2 - 1920 ROBERT F KRAUTER
Filed ....., 191.... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 30 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

(a) Chron. Endocarditis 4 hrs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Sig. [illegible] M. D.

(Address) [illegible]

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Sept. 3 1920

20-UNDERTAKER, Chas. H. Johnson ADDRESS 1167 N. Caroline

may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 46210

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46210

CERTIFICATE OF DEATH.

108

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3521 Benson St ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth A. Broge

(Residence in Baltimore: No. 3521 Benson St ST.; 40 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Aug (Month) 17 (Day), 1880 (Year)

7-AGE	If LESS than 1 day,
40 yrs. 0 mos. 15 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mill Hand
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country). Balto Co.

PARENTS.

10-NAME OF FATHER. John Geoge

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Sarah Short

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Geoge

(Address) 3539 Roland Ave

15-

SEP 2 - 1920 Filed....., 191.....

Robert P. Harrison, Registrar.

Burial Permit C...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 1 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Aug 12 1920, to Sept 1 1920, that I saw h[illegible] alive on Aug 31 1920, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

[illegible] See remarks

Malignant tumor of breast, follow[illegible]

days prior to [illegible] for Appendicitis

abscess (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute cirrhosis with

portal obstruction (Duration) ..... yrs. ..... mos. 11 ds.

(Signed) C. P. Norment M. D.

Sept 2, 1920. (Address) 3643 Eberhard Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Marys R	Sept 4, 1920
20-UNDERTAKER	ADDRESS
A S Marshall	355 Fall Rd

Use instructions on back of certificate.

D.46211 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46211

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Eutaw & Franklin Sts. St.: 17 WARD) REGISTERED No. C 175,001

2-FULL NAME George Roger Grimes

(Residence in Baltimore: No. Non resident (Balto. Co, Md.) St.: yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	white	single

6-DATE OF BIRTH, October 4, 1914
(Month) (Day) (Year)

7-AGE, 5 yrs. 11 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none (child)
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Co. Md.

PARENTS.

10-NAME OF FATHER, Everett R. Grimes

11-BIRTHPLACE OF FATHER (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER Beula Akehurst

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Everett R. Grimes.

(Address) Balto. Co. Md.

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 1, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
automobile accident (Instantaneous)
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) J. D. Hemmeter M. D.
(Coroner.)

September 1, 1920 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pleasant Grove — DATE OF BURIAL, Sept 4, 1920

20-UNDERTAKER A. S. Marshall — ADDRESS 2539 Pulaski Rd

SEP 8 1920 Robert P. Harrison, Burial Permit Clerk.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.46212

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46212

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 848 W. 33 St ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Leslie Baker

(Residence in Baltimore: No. 848 W. 33 St St.; 8 yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Feb (Month) 1 (Day), 1912 (Year)

7-AGE, ...yrs. 7 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Howard R. Baker

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Philippine Hoffman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Baker

(Address) 848 W. 33 St

15-

Filed Sept 2, 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ~~August~~ September (Month) 2 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 31 1920, to Sept 2 1920, that I saw him alive on Sept 2 1920, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) unknown

(Duration) ....yrs. ....mos. ....ds.

(Signed) ~~Sullivan~~ M.D.

Sept 2, 1920 (Address) 863 W 34 St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Ft Mary's Hospital	Sept 3, 1920
20-UNDERTAKER	ADDRESS
A. S. Marshall	353 Fulton Ave

Penalty for not filling out this certificate. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D46213 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D46213.

CERTIFICATE OF DEATH. 150

1-PLACE OF DEATH Baltimore, Md.

CITY OF BALTIMORE: (No. 5315 Etheldert Ave ST.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME "Baby" Frere

(a) RESIDENCE. NO. 5315 Etheldert Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 30/1920

7 AGE — Years — Months 3 Days (If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Francis Frere

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Minnie Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Ralph Frere 5315 Etheldert Ave

15 Filed SEP 3 - 1920 ROBERT E [illegible] Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 31 1920, to Sept 2nd 1920, that I last saw him alive on Sept 2nd 1920, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows: Chr Valvula Heart Disease Congenital

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Child Birth

(duration) yrs. mos. ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred A Clark M. D.

, 19 (Address) 4 W 49 Pk. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: Sept-3 1920

20 UNDERTAKER: New Cork

ADDRESS: W. + G. Ave

FOR is very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46214

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 46214

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2251 Mc Elderry ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Humphreys

(a) RESIDENCE. NO. 2251 Mc Elderry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 10 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Harry Humphreys

6 DATE OF BIRTH (month, day, and year) Oct 25/85

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	10	6	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Malefsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Julia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Harry Humphreys
(Address) 2251 Mc Elderry St

15 Filed SEP 3 - 1920 ROBERT A. BRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1920, to Aug 31, 1920, that I last saw h[illegible] alive on Aug 31, 1920, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White M. D.
9/2, 1920 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Sept 3 1920
20 UNDERTAKER Philip Herwig	ADDRESS 206 Orleans

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified. Give

Spec.—6-3-19—H. P. Co.—1000 Bks.

D46215 HEALTH DEPARTMENT—CITY OF BALTIMORE D46215

28

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1152 Scott St. ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Yakel. (Yaekel)

(a) RESIDENCE. NO. 1152 Scott St. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) ~~HUSBAND of~~ WIFE of Matilda Yaekel

6 DATE OF BIRTH (month, day, and year) Oct 25/59

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Street Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Yaekel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Matilda Yaekel

(Address) 1152 Scott St

15 Filed SEP 3 - 1920 19 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/1/1920

17

I HEREBY CERTIFY, That I attended deceased from July First, 1920, to Sept 1 1920, 19, that I last saw him alive on Sept 1 /1920, 19, and that death occurred, on the date stated above, at 2/30 PM m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Shepherd Drain M.D. M. D.

19 (Address) 1227 Columbia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept. 4 1920
20 UNDERTAKER	ADDRESS 2016
Philip Hennig	Aliceau

TION is very important. See instructions on back of certificates.

...may be properly classified. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46216 D46216

CERTIFICATE OF DEATH

1-PLACE OF DEATH Union Memorial Hospital 20 REGISTERED NO. C

CITY OF BALTIMORE: (No. 1514 Division ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Archie L. Dettor

(Residence in Baltimore: No. 5307 Melvin Ave Arlington Md. St.; 18 yrs. 3 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. May 26, 1902
(Month) (Day) (Year)

7-AGE. 18 yrs. 3 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Mr. Robert J. Dettor, Jr.

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Grace G. Daily

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt J. Dettor Jr.

(Address) 5307 Melvin Ave

15- SEP 3 - 1920 ROBERT F. BRAUTER
Filed....., 191.... Registrar of Vital Statistics.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 1, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 24 1920, to Sept. 1 1920, that I saw him alive on Sept 1 1920, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Streptococcus Viridans septicemia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Endocarditis - Pul. infarct

(Duration) yrs. mos. 10 ds.

(Signed) J. H. Zimmerbaugh M. D.

Sept. 1, 1920 (Address) U. M. H.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 8 ds. In the State 18 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Arlington, Md.

Former or usual residence 5307 Melvin Ave. Arlington

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Sept. 4, 1920
20-UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W. North Ave

Important. See instructions on back of certificate.

D46217

HEALTH DEPARTMENT---CITY OF BALTIMORE

D46217

CERTIFICATE OF DEATH

151

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 513 Bruce St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Premature birth (Baby Caplan)

(Residence in Baltimore: No. 513 Bruce St. St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6-DATE OF BIRTH: September 2, 1920 (Month) (Day) (Year)

7-AGE: — yrs. mos. ds. If LESS than 1 day, 2 hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer): NO

9-BIRTHPLACE (State or country): Balto Md. U.S.A.

PARENTS

10-NAME OF FATHER: Chas. Caplan

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: Lena Stein

13-BIRTHPLACE OF MOTHER (State or country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Caplan

(Address) 513 Bruce St

15- Filed SEP 3 - 1920 191- ROBERT B. BEAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: September 2, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 2, 1920, to, Sept 2 1920, that I saw him alive on Sept 2 1920, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Premature birth

2 hours

(Duration) ..... yrs ..... mos ..... ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs ..... mos ..... ds.

(Signed) Samuel Silverstein M. D.

....., 191.... [Address] 22 S. Broadway

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Pikesville Cemetery | DATE OF BURIAL: Sept 2, 1920

20-UNDERTAKER: Jack Lewis | ADDRESS: 1111 E. Baltimore

state CAUSE OF DEATH in plain terms, so that the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should TION is very important. See instructions on back of certificate. that it may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

L046218 HEALTH DEPARTMENT—CITY OF BALTIMORE L046218

CERTIFICATE OF DEATH. 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 Dolphin St.; 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T Turner

(a) RESIDENCE. No. 223 Dolphin St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer) Hardware Store

(c) Name of employer Wm H Shellington

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Thomas Turner

(Address) 223 Dolphin St

15 Filed SEP 3 - 1920 19 ROBERT J. LEUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 29, 1920, to Aug 31, 1920, that I last saw h.. alive on Aug 1, 1920, and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

Lymphosarcoma (Neck)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas H Faulee, M. D.

Aug 31, 1920 (Address) 1504 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int Auburn Cem	Sept 3 1920
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Orleans

THIS CERTIFICATE OF DEATH must be filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D46219

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46219

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 428 Furrow St ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marlette E. Cooper.

(Residence in Baltimore: No. 428 Furrow St St.; 0 yrs., 3 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Infant

6-DATE OF BIRTH, May (Month) 11 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
no yrs. 3 mos. 22 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, George Cooper.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Margaret Baumstein

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Cooper

(Address) 428 Furrow St

15-SEP 3 - 1920 Filed....., 191.....

ROBERT E KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 2 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24 1920, to Sept 2 1920, that I saw her alive on Sept 1 1920, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Diarrhea and Enteritis

(Duration) no yrs. no mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Raymond J. Glenn M. D.

Sept 3, 1920 (Address) Catherine

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL
Western Cemetery	Sept 3, 20

20-UNDERTAKER	ADDRESS
F. B. Keppert	2230 Fredk Ave

Important. See instructions on back of certificate. Every statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46220

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46220

CERTIFICATE OF DEATH.

77

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5925 Bellona Av ST.; 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Watson Smith

(a) RESIDENCE. No. 5925 Bellona Av ST., 28 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 83 yrs. 11 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (none)

6 DATE OF BIRTH (month, day, and year) Sept 3/1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	11	28	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Warrenton Virginia

PARENTS

10 NAME OF FATHER Thomas Smith

11 BIRTHPLACE OF FATHER (city or town) ? ? (State or country) England

12 MAIDEN NAME OF MOTHER Mary Dean

13 BIRTHPLACE OF MOTHER (city or town) Alexandria (State or country) Virginia

14 Informant Mrs Josephine Dean Cronmiller (niece)
(Address) 219 N Lafayette av

15 Filed SEP 3 - 1920 19 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 16 1920, to Sep 1 1920, that I last saw h[illegible] alive on Sep 1 1920, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Angina Pectoris (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dyspnea

(Signed) Geo W Boakey, M. D.

19 (Address) 5835 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL Sept 3 1920

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM T. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 46221

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46221

CERTIFICATE OF DEATH.

1

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 Raborg ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Hall

(a) RESIDENCE. NO. 805 Raborg ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Blk	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Hall

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Saml Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Georgiana Skinner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Clarence E Payne (Address) 607 N Paca St

15 Filed SEP 3 - 1920 ROBERT F KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1st 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 31st, 1920, to Sept 1, 1920, that I last saw her alive on August 31, 1920, and that death occurred, on the date stated above, at 10 a- m.

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Enteric Fever (duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Gustav Goldmann, M. D

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn DATE OF BURIAL Sept 3 1920

20 UNDERTAKER John H Toadvine ADDRESS 42 N Paca St

John H Toadvine

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D46222 HEALTH DEPARTMENT—CITY OF BALTIMORE D46222

120

CERTIFICATE OF DEATH.

REGISTERED No. C.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 627 W. Lanvale ST.: 17 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Knopf

(Residence in Baltimore: No. 627 W. Lanvale St. St.; yrs. 34 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	married

6-DATE OF BIRTH, January 1, 1866
(Month) (Day) (Year)

7-AGE, 54 yrs. 9 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles Knopf

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Tamar Hall

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Knopf Jr.

(Address) 627 W. Lanvale

15- SEP 3 - 1920 filed ..... 191.... ROBERT B. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 1, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Organic Heart disease

(Duration) yrs. 4 mos. ds.

(Signed) J. A. D. Hennessey M. D.
(Coroner.)

Sept. 2, 1920 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Sept 4, 1920
20-UNDERTAKER	ADDRESS
Edw. Ringgold	1463 N. Carey St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 46223 HEALTH DEPARTMENT—CITY OF BALTIMORE D 46223

105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2116 Glenwood Ave ST.; 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Valentini

(a) RESIDENCE. No. 2116 Glenwood Ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Andrew Valentini

6 DATE OF BIRTH (month, day, and year) [illegible] 20. 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Cherigo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Margaret Donderio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant F. J. Valentini
(Address) 2116 Glenwood Ave

15 Filed ....., 19... [illegible] Registrar

SEP 3 – 1920 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1920

17 I HEREBY CERTIFY, That I attended deceased from August 20 1920, to Sept 1, 1920

that I last saw her alive on Sept 1, 1920,

and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Diarrhea - Duration 6
Senile Debility

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Aged

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph L. Valentini M. D.

....., 192.. (Address) 2116 N. Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Sept 4 1920
20 UNDERTAKER	ADDRESS
E. J. Fanning & Son	1938 E. Lafayette Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46224

HEALTH DEPARTMENT—CITY OF BALTIMORE

108 D46224

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. St.: 8 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Foote.

(a) RESIDENCE. No. 1537 Patterson Park Ave St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 26' 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School boy.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Zachariah A. Foote

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Annie A. Burkhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Mrs Zachariah A. Foote
(Address): 1537 N. Patterson Park Ave

15 Filed SEP 3 - 1920 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-2 1920.

17 I HEREBY CERTIFY, That I attended deceased from Sept 2 , 1920 , to Sept 2nd , 1920 ; that I last saw him alive on Sept 2nd , 1920 ; and that death occurred, on the date stated above, at 12 10 p m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Ruptured Appendix

(duration) yrs. 1 mo 7 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 9/2/20

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) Aby J Greene, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept. 6 1920
20 UNDERTAKER: Henry Hosch & Son	ADDRESS: 1301 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46225

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46225

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 Somerset ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Schisler

(a) RESIDENCE. NO. 1110 Somerset ST., 10 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. — mos. — ds. How long in U. S., if of foreign birth? 68 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed or divorced HUSBAND of (or) WIFE of the late Lucentia Schisler

6 DATE OF BIRTH (month, day, and year) Apr. 13th 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer) Ex cavator

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Schisler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Miss. Winnie Schisler

(Address) 1110 Somerset St

15 Filed SEP 3 - 1920 19.. ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1920

17

I HEREBY CERTIFY, That I attended deceased from June 12th. 1920. to Sept 2nd. 1920.

that I last saw him alive on Sept 2nd. 1920. 19..

and that death occurred, on the date stated above, at 10 XX P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate,
Cystitis,
Dental Sepsis.

(duration) yrs. 6mos. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical only.

(Signed) Edward Zeller M. D.

19 19 (Address) 1419 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sep 6 1920
20 UNDERTAKER	**ADDRESS**
Henry Bouck & Son	1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46226 D46226

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1205 W Fayette ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Dyson

(a) RESIDENCE. NO. 1205 W Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 12 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of — William Dyson

6 DATE OF BIRTH (month, day, and year) Jan 11 - 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ———— 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Stafford Co Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Robert Dyson (Address) 1205 W Fayette St

15 Filed SEP 3 - 1920 19 ROBERT P. LAZENBY Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2 - 1920

17 I HEREBY CERTIFY, That I attended deceased from July 19 1920 to Sept 2 1920, that I last saw her alive on Sept 2 1920, and that death occurred, on the date stated above, at 7-30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis & Senile Arthrio sclerosis

(duration) Over 2 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Va

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam

(Signed) F. Henry Doyle M. D.

. 19 (Address) 1203 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem,	Sept 5 1920
20 UNDERTAKER	ADDRESS
John J Cowan & Son,	501 Holliday.

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

946227

HEALTH DEPARTMENT—CITY OF BALTIMORE

946227

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2416 W Balto ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Stewart

(a) RESIDENCE. No. 2416 W Balto ST., 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Jan 15 1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Leather 086

(b) General nature of industry, business, or establishment in which employed (or employer) Tanner

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md

PARENTS

10 NAME OF FATHER Geo Stewart

11 BIRTHPLACE OF FATHER (city or town) Cabell Co (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Rupp

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co (State or country) Md

14 Informant Mrs Charles L Sayerwein (Address) 2416 W. Balto St

15 Filed SEP 3 - 1920 ROBERT P. PRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1920, to Sept 2, 1920, that I last saw h m alive on Sept 1, 1920, and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Foreman

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Mitral & Tricuspid Disease Heart, Pneumonia

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Howard L Keller, M. D.

9/2 19 20 (Address) 2027 E Oriole St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept. 4 1920
20 UNDERTAKER	ADDRESS
Geo. L Schnaderbeck	2101 Eutaw Pl

IMPORTANT.—Physicians will please write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Ehrig

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46228

CERTIFICATE OF DEATH.

109 D 46228

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2038 W Pratt ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard Ehrig

(a) RESIDENCE. NO. 2038 W Pratt ST., 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E. Ehrig

6 DATE OF BIRTH (month, day, and year) Jan 6 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse Shoer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna E Ehrig

(Address) 2038 W. Pratt St

15 Filed SEP 3 - 1920, 19 ROBERT A. BAUER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to Sept 2, 1920, that I last saw h live on Sept 2, 1920, and that death occurred, on the date stated above, at 7.9, m.

The CAUSE OF DEATH* was as follows:

Toxaemia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Strangulated Hernia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Harwood Kelly M. D.

9/3. 1920 (Address) 2027 W Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 4 1920
20 UNDERTAKER	ADDRESS
Geo. L. Schwatka & Bro.	Fells Inc

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

important. See instructions on back of certificate. Typewriter characters. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46229

CERTIFICATE OF DEATH.

D 46229

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 N. Washington St.; 8 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Wm Byrne

(Residence in Baltimore: No. 1319 N. Washington St.; 9/12 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Sept 1, 1920
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 1 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 0ff
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm E Byrne

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Anna M Garrett

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm E Byrne

(Address) 1319 N. Washington

15-

Filed ....., 191.. ROBERT B KRAUTER

SEP 3 - 1920 Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 2, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Sept 2 1920, that I saw h[illegible] alive on Sept 2 1920, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) ..... yrs. ..... mos. X ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno L Frisham M. D.

Sept 3, 1920 (Address) 1823 N. West Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, A Marys - Irvine — DATE OF BURIAL, Sept 3, 1920

20-UNDERTAKER Robt Johnson Sr — ADDRESS 1414 Bway

Spec. 6-9-19—H. P. Co.—1000 Bks.

2046230 ✓ 2046230

HEALTH DEPARTMENT—CITY OF BALTIMORE

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 304 E Hamburg ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Patrick Dan

(a) RESIDENCE. NO. 304 E Hamburg ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 8 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles K Ellis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Clancy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mary Clancy (Address) 304 E Hamburg St

15 Filed SEP 3 - 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/2 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 26 1920, to Sept 2, 1920, that I last saw h[illegible] alive on Sept 1, 1920 and that death occurred, on the date stated above, at 9.50 a.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) C Mikesell, M. D.

, 19 (Address) 1217 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cem — DATE OF BURIAL Sept 4 1920

20 UNDERTAKER F. A. Traucht Son — ADDRESS 763 Hanover

TION is very important. See instructions on back of certificates.

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

Robbio

D46231

HEALTH DEPARTMENT—CITY OF BALTIMORE

1042046231

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 E. Clement St.; 24 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest N. Robbio

(Residence in Baltimore: No. 612 E. Clement St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	S

6-DATE OF BIRTH, June 2, 1920
(Month) (Day) (Year)

7-AGE, 0 yrs. 3 mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... —
(b) General nature of industry, business, or establishment in which employed (or employer)..... —

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Harry Robbio

11-BIRTHPLACE OF FATHER (State or Country), New Castle, Pa.

12-MAIDEN NAME OF MOTHER Bessie Redell

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Robbio

(Address) 612 E. Clement St. City

15-SEP 3 - 1920 Filed....., 191... ROBERT E KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 2, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 28 1920, to Sept 2 1920, that I saw h[illegible] alive on Sept 1 1920, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

..... (Duration)....yrs....mos....4....ds.

CONTRIBUTORY (Secondary) Diarrhoea

..... (Duration)....yrs....2....mos.....ds.

(Signed) W. Blackburn M. D.

Sept 2, 1920 (Address) 1248 Clem

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Pauls Cem	Sept 4, 1920
20-UNDERTAKER	ADDRESS
F. A. Frances Son	708 Hanover St

important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.46232 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46232

CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5116 Centre St., Govans ~~St.~~ 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Rowney

(a) RESIDENCE. No. 5116 Centre St., Govans ~~St.~~ WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louisa Rowney

6 DATE OF BIRTH (month, day, and year) March 29, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 070

(b) General nature of industry, business, or establishment in which employed (or employer) Apartment-house

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Thomas Rowney

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant James B. Rowney,
(Address) 5116 Centre St, Govans.

15 Filed SEP 3-1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2 1920

17 I HEREBY CERTIFY, That I attended deceased from January, 1920, to Sep 2nd, 1920, that I last saw him alive on Sep. 2nd, 1920, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy. Microscope.

(Signed) Wm. T. Watson, M. D.

Sep 3, 1920 (Address) 212 S St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept. 4 1920
20 UNDERTAKER	ADDRESS
Wm. C. Black,	927 N. Broadway.

...may be properly classified. Exact statement of OCCUPA-
...TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46233 HEALTH DEPARTMENT—CITY OF BALTIMORE D46233

CERTIFICATE OF DEATH. 108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 843 W. Ostend ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Carr

(a) RESIDENCE. NO. 843 W. Ostend ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Steve Carr

6 DATE OF BIRTH (month, day, and year) — 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer R.S. Goldstein, Sons

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Priscilla Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Samuel Cornish

(Address) 843 W Ostend

15 Filed SEP 3 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/1/ 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 25th, 1920, to Sept 1, 1920, that I last saw her alive on Sept 1, 1920, and that death occurred, on the date stated above, at 8:10 a m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Gastritis; Appendicitis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Lee Bowley, M. D.

, 19 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 4 1920
20 UNDERTAKER	ADDRESS
Daniel Easton	64 ms

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M.& T.—2000 Bks.

D.46234 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46234

CERTIFICATE OF DEATH. † 120

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 4422 St George Ave St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Freedman

(Residence in Baltimore: No. 4422 St. George St.; yrs. 2 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M. 4-COLOR OR RACE, Col. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb. 28, 1872. (Month) (Day) (Year)

7-AGE, 48 yrs. 6 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, George Freeman

11-BIRTHPLACE OF FATHER (State or Country), S. C.

12-MAIDEN NAME OF MOTHER Rebecca Brown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Florence Hawkins

(Address) 4422 St. George ave

15-

Filed SEP 3 - 1920, 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 2nd, 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1920, to Sept 2nd 1920, that I saw him alive on Sept 1st 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. 10 ds.

(Signed) D. Grant Smith M. D.

Sept 3, 1920. (Address) 3541 W. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence New Port News Va

19-PLACE OF BURIAL OR REMOVAL, New Port News Va — DATE OF BURIAL, Sept 7, 1920.

20-UNDERTAKER Geo. Holland — ADDRESS 1931 Druid Hill Ave

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.46235

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.46235

CERTIFICATE OF DEATH.

119

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 Cumberland ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Pauline Ruppert

(a) RESIDENCE. No. 611 Cumberland ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) Dec. 8, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Operator 186

(b) General nature of industry, business, or establishment in which employed (or employer) Straw Hat Mfr.

(c) Name of employer Townsend & Grace Baltimore, Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Edw. A. Ruppert

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary V. Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary V. Ruppert
(Address) 611 Cumberland St.

15 Filed SEP 3-1920 By Robert P. Harris Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-2 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 3, 1920, to Sept 2, 1920, that I last saw h cr alive on Sept 2, 1920, and that death occurred, on the date stated above, at 9.15 a m.

The CAUSE OF DEATH* was as follows: OVER

Uraemia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? U.A. -

(Signed) McBoumanHood, M. D.

9/3, 1920 (Address) 636 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Sept. 4 1920
20 UNDERTAKER	ADDRESS
Henry W. Meare & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.46236

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46236

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vera Lapapta

(a) RESIDENCE. NO. 610 W. Conway ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7-1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Lapapta.

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Vallie Lauter

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant andrew Ap Lapata
(Address) 610 W Conaway

15 Filed SEP 3-1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1920, to Sept 3, 1920, that I last saw her alive on Sept 3, 1920, and that death occurred, on the date stated above, at 1:45 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B MacGowan, M. D.

Sep 3 1920 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept 4 1920
20 UNDERTAKER	**ADDRESS**
John Greblunas	426 S Paca St

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46237 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46237

CERTIFICATE OF DEATH.

37

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 166 W. Hamburg ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Reed

(a) RESIDENCE. NO. 166 W. Hamburg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1886

7 AGE 34 Years Months Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Charles Brown
(Address) Va

15 Filed SEP 4 1920, 19 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1920, to Sept 1, 1920, that I last saw him alive on Sept 1, 1920, and that death occurred, on the date stated above, at 3.20 p m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? ....Date of ....

Was there an autopsy? ....

What test confirmed diagnosis? Physical exam & ....

(Signed) C. L. Jackson, M. D.

, 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn ct	Sept 4 1920
20 UNDERTAKER	ADDRESS
L. W. Brown & Son	1014 W. Monroe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Syphilis

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46238

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D.46238

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3718 Park Heights Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Herrmann

(a) RESIDENCE. No. 3718 Park Heights Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick Herrmann

6 DATE OF BIRTH (month, day, and year): April 18 35

7 AGE: Years 85 Months 4 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Richard Spencer

(Address) 3718 Park Heights Ave

15 Filed SEP 4 - 1920 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 3 - 1920

17

I HEREBY CERTIFY, That I attended deceased from June 6, 1920, to Sept 3, 1920

that last saw her alive on Sept 2, 1920,

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Chronic interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James B. Ashman M. D.

(Address) 4012 Park Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept 6 1920

20 UNDERTAKER: Wm. J. Hammond Sons — ADDRESS: Northern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.46239

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46239

CERTIFICATE OF DEATH.

37

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 317 S. Sharp St. ST. 32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Turner. (C)

(Residence in Baltimore: No. 317 S. Sharp St. St.; 32 yrs., 10 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female.	Colored	Single.

6-DATE OF BIRTH. October 9th. 1887, 1 (Month) (Day) (Year)

7-AGE. 32 yrs. 10 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. John Turner. (C)

11-BIRTHPLACE OF FATHER (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER. Rebecca Cotton. (C)

13-BIRTHPLACE OF MOTHER (State or Country). Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harrison Felton. (C)

(Address) 317 S. Sharp St.

15- SEP 1 - 1920 Robert P. Harrison,

Filed....., 191..... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. September 2nd. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture of an Aortic Aneurism.

Syphilis.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Sept. 3, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	Sept. 5, 1920
20-UNDERTAKER John H. Toadvin	ADDRESS 142 W. Hill St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.46240 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46240

CERTIFICATE OF DEATH.

50

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 538 N Bond- ST.: 7 WARD)

2-FULL NAME Annie Jones

(Residence in Baltimore: No. 538 N Bond St.: yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Not known, (Month) (Day) 1 (Year)

7-AGE, 60 about yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) Ov

9-BIRTHPLACE, (State or Country), Talbot County

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Young

(Address) 536 N. Bond St

15- Rcvd. SEP 4 1920, 191

Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 2 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Edema

(Duration) yrs. mos. 1 ds.

Signed) Geo Edw Pleiz M. D.
(Coroner.)

9/3/20 1921 (Address) 743 N Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cem

DATE OF BURIAL, Sept 4, 1920

20-UNDERTAKER Theo White

ADDRESS 113 S. Wolfe st

CAUSE OF DEATH in plain terms. AGE should be stated EXACTLY. PHYSICIANS should state carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46241

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46241

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1618 Shakespheare ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph wysocki

(a) RESIDENCE: NO. 1618 Shakespheare ST., 7 WARD. 2

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 15 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — ans

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Wysocki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Wazyama andrykatka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Frank Wysocki

(Address) 1618 Shakespheare St

15 Filed SEP 4 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1920, to Sept. 5, 1920.

that I last saw him alive on Sept. 3, 1920.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) John H. Rehberger, M. D.

19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Sep 4 1920

20 UNDERTAKER — ADDRESS

John F. Weber 1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D.46242

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46242

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH 2 Fayette Square Nurs 19 REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... St. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Curry

(Residence in Baltimore: No. 1215 W. Franklin St.; ...yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. Septem 3rd, 1920
(Month) (Day) (Year)

7-AGE. ...yrs. ...mos. 1 da.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER. Myron S. Curry

11-BIRTHPLACE OF FATHER (State or Country). Shawe Md

12-MAIDEN NAME OF MOTHER Sadie V Burd

13-BIRTHPLACE OF MOTHER (State or Country) White Hall Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Sylvester MD

(Address) 301 N Carrollton Ave

15- Filed SEP 4 - 1920, 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 3rd, 1920.
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Sept 3rd 1920 to Sept 4th 1920, that I saw him alive on Sept 3rd 1920, and that death occurred, on the date stated above, at 1.15 a m.

The CAUSE OF DEATH* was as follows:

Atelectasis

Following Prolapsed Cord

CONTRIBUTORY (Secondary) Pubic Union (Duration) ...yrs. mon. ...da.

(Signed) Howard Sylvester M. D.

9/4, 191.. (Address) 301 N Carrollton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...da. In the State ...yrs. ...mos. ...da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, White Hall. Balto Co Md

DATE OF BURIAL, Sept. 4., 1920

20-UNDERTAKER Geo W Little

ADDRESS 531 N Fremont Ave

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very ... Second Sale ... properly classified. ... as plain terms, so that it may be

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46243 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46243

CERTIFICATE OF DEATH.

172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hosp ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Wellener

(a) RESIDENCE. NO. Gay & Washington ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	M.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 84	—		

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed. (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER James Lewis

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Harriett Russell

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Phil ip T. Donahue
(Address) 1807 N. Carolina St

15 Filed Sept 4 1920 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 7, 1920, to Sept 3, 1920, that I last saw h.r alive on Sept 3, 1920, and that death occurred, on the date stated above, at 2 9. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Fractured Hip (Age)

(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Frank C. Marino, M. D.

Sept 3, 1920 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Pk	Sept 4 - 1920
20 UNDERTAKER William Cook	ADDRESS 502 S. North Ave

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.46244

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46244

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH Phipps Clinic Johns Hopkins Hosp. REGISTERED NO. C

CITY OF BALTIMORE: (No. ..... ST.; 9 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgia Cornwell

(Residence in Baltimore: No. 1727 Asquith St St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	widowed

6-DATE OF BIRTH, Feb 12, 1871.
(Month) (Day) (Year)

7-AGE, 49 yrs. 6 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework for yself
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Smith

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Amanda

13-BIRTHPLACE OF MOTHER (State or Country), unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leslie B. Johnson

(Address) Johns Hopkins Hosp

15- Robert P. Harrison,

Filed ....., 191.....
Registrar.
Burial Permit Clerk.

SEP 4 - 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 1st, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 30 1920, to Sept 1st 1920, that I saw h[er] alive on Sept 1st 1920, and that death occurred, on the date stated above, at 1140 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma, Large intestine

(Duration) 2 yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction, ventral

(Duration) yrs. 1 (?) mos. ds.

(Signed) Leslie B. Johnson M. D.

Sept 2nd, 1920. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 33 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary County, Hayden — DATE OF BURIAL, Sept 4, 1920

20-UNDERTAKER George J Rutt — ADDRESS 1735 Hayford Ave.

SEE IMPORTANT: PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.46245 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46245

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Joseph Hospital St. 6 WARD) REGISTERED No. C 175-002

2-FULL NAME Chas E Linton.

(Residence in Baltimore: No. 1838 N Wolfe St. (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, April 14, 1896.
(Month) (Day) (Year)

7-AGE, 24 yrs. 4 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Butcher
(b) General nature of industry, business, or establishment in which employed (or employer): 013

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Edward M Linton

11-BIRTHPLACE OF FATHER (State or Country), Richmond Va

12-MAIDEN NAME OF MOTHER Bertie B McCurdy

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward M Linton

(Address) 1838 N Wolfe st

15- Filed SEP 4 1920, 191.... Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 2, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Contusion of Skull Coma

(Duration) 1 yrs. 5 mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

9/4/20 1921 (Address) 1538 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Cemetery	Sept 6, 1920

20-UNDERTAKER,	ADDRESS
Robt J Turner & Sons	1412 E Broadway

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.46246 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46246

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1112 Cooksie St. ST.: 24 WARD) 104 REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H.Conklin.

(Residence in Baltimore: No. 1112 Cooksie St. St.; —yrs., 4 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, March 9th. 1920., 1 (Month) (Day) (Year)

7-AGE, ------ yrs. 4 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None. ~~0~~
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Henry Conklin.

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania.

12-MAIDEN NAME OF MOTHER Clara May.

13-BIRTHPLACE OF MOTHER (State or Country), England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Conklin,(mother)

(Address) 1112 Cooksie St.

15- Filed SEP 4 - 1920, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 3rd. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Otto M Rosenhardt M. D. (Coroner.)

Sept. 3., 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	....., 19...
20-UNDERTAKER	ADDRESS
Mary E. Edwards Son	1228 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

at Mayer

20.46247

HEALTH DEPARTMENT—CITY OF BALTIMORE

20 46247

CERTIFICATE OF DEATH.

+92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lodge Corbett.

(a) RESIDENCE. NO. 789 Lemuel St Norfolk St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va.,

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant. Rev Johnson
(Address) 1429 Fleet St

15 Filed SEP 4 - 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1920.

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1920, to Aug 27, 1920, that I last saw him alive on Aug 27, 1920, and that death occurred, on the date stated above, at 11 30a m.

The CAUSE OF DEATH* was as follows:

OVW

Meningitis (pneumococci)

(duration) yrs. mos. One ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? no.

What lest confirmed diagnosis? Clinical

(Signed) Abr J Griffis M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Crabtree Cemetery	Sept 7 1920
20 UNDERTAKER	ADDRESS
Randall & Hippel	1118 E 21st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.46248 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46248

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1514 Rutter ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John G. Murdock

(Residence in Baltimore: No. 1514 Rutter St ... St.; 20 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1854 (Year)

7-AGE, 65 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Sarah Murdock

(Address) 1514 Rutter Street

15- Filed SEP 4 - 1920, 19.. Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 3 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1912, to Sept 3 1912, that I saw him alive on Sept 2 1912, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

Nephritis

(Duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. Whitridge Williams M. D.

....., 191... (Address) 1202 W. Lee

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Sept. 6..., 19..
20-UNDERTAKER John M. Johnson	ADDRESS 1234 Etting St

IMPORTANT. See instructions on back of certificate. Cause of death must be properly classified. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

D.46249

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46249

CERTIFICATE OF DEATH.

151

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 S. Green ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beby Boyer

(Residence in Baltimore: No. 604 S. Green St.; ....yrs....mos....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH. September 3, 1920. (Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 1½ da. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles Boyer

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Georgiana Nash

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-
Filed ....., 191....
Robert P. Harrison, Registrar.
SEP 4 - 1920
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 3, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 2 1920, to Sept. 3 1920, that I saw her alive on Sept. 3 1920, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Premature birth .....

..... (Duration) ....yrs. ....mos. 1½ da.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....da.

(Signed) J. Morris Rees M. D.

Sept. 4, 1920 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	Sept 4, 1920
20-UNDERTAKER	ADDRESS

17-182

Important. See instructions on back of certificate. be properly classified. Exact statement of OCCUPATION is very

D 46250 HEALTH DEPARTMENT—CITY OF BALTIMORE D 46250

CERTIFICATE OF DEATH.

151

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3919 Fait ave ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carl Hale Hildt

(Residence in Baltimore: No. 3919 Fait ave

St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Infant

6-DATE OF BIRTH, August 14, 1920
(Month) (Day) (Year)

7-AGE, 3 Weeks
.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Harry Hildt

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Maud Heath

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maud Heath

(Address) 3919 Fait ave

15- SEP 4 - 1920 Robert P. Harrison,
Filed....., 191.....
Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 2, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Investigation (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Sept 2 - 20 - 8 15 P.M.
(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Claire Von Kuske M. D.
(Coroner.)
Sept 2, 1920 (Address) 1800 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Sept 5; 1920
20-UNDERTAKER	ADDRESS
Wendell Hepp & Son	37 S Carey St

IMPORTANT. See instructions on back of certificate.

D46251

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46251

CERTIFICATE OF DEATH.

150

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1849 Lamms ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Alton

(Residence in Baltimore: No. 1849 Lamms St

St.: yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	colored	Single

6-DATE OF BIRTH, ... May (Month) 28 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
.....yrs. 3 mos. 6 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... (Infant)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joshua Alton

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Priscilla Isaac

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joshua Alton

(Address) 1849 Lamms St

15-

Filed SEP 4 1920, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... September (Month) 3 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Bronchial Pneumonia

.....

..... (Duration) .....yrs. 3 mos. 6 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Hennessy M. D.
(Coroner.)

September 3 1920 (Address) 702 E Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters	Sept. 4, 1920

20-UNDERTAKER	ADDRESS
Edw. Ringgold	1763 Carey St

GE should be stated EXACTLY. PHYSICIANS should state
operly classified. Exact statement of OCCUPATION is very
important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

846252

HEALTH DEPARTMENT—CITY OF BALTIMORE

846252

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1576 Marshal ST.; 24 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Smith

(Residence in Baltimore: No. 1576 Marshal St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Nov 7, 1916
(Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jos Smith

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Agnes Daly

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane Smyth

(Address) 1516 Marshall St

15-

Filed SEP 4 1920, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 2, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 23 1920, to Sept 2 1920, that I saw h*im* alive on Sept 2 1920, and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria Toxemia

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) Toxaemia

(Duration) ....yrs. ....mos. 2 ds.

(Signed) Howard H. Warner M. D.

Sept 2, 1920 (Address) 2604 Garrison Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 4 mos. 5 ds. In the State ....yrs. 4 mos. 5 ds.

Where was disease contracted, if not at place of death? 1516 Marshal St.

Former or usual residence 1516 Marshal St.

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem

DATE OF BURIAL, 9/4, 1920

20-UNDERTAKER Jos F Finkey Sons

ADDRESS 318 Light St

D 46253

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46253

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH 1028 Eastern ave 2b

CITY OF BALTIMORE (No. ~~Linden Ave~~ St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter miller

(Residence in Baltimore: No. 12 Belmar ave St. 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Wht

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Jan 19, 1892 (Month) (Day) (Year)

7-AGE, 28 yrs. 7 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Salesman 066
(b) General nature of industry, business, or establishment in which employed (or employer)..... Wine Merchant

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Frank Miller

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Anna Schultz

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alga Miller

(Address) 12 Belmar ave

15- SEP 4 - 1920 Robert P. Harrison,

Filed ..... 191.... Registrar.

Burial Permit Given.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 1, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by pistol

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. R. Gundry (Coroner.) M. D.

9-2-20 (Address) 1 E Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery

DATE OF BURIAL, Sept 4 1920

20-UNDERTAKER J. F. Moran

ADDRESS 3000 E Baltimore

IMPORTANT. See instructions on back of certificate. Information should be stated EXACTLY. PHYSICIANS should state may be properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46254

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D46254

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Reverend Thos. J. Wilson

(a) RESIDENCE. NO. St. Mary's Church WARD Ellicott City Md.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Priest

6 DATE OF BIRTH (month, day, and year) Oct. 21st 1848

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
71	10	14	

8 OCCUPATION OF DECEASED 018

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Priest

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mrs. Mary P. Agnew

(Address) 1825 E. Balto St.

15 Filed SEP 4 1920 19 Robert P. Harrison, Registrar

(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2 1920

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1920, to Sept 2, 1920, that I last saw him alive on Sept 2, 1920, and that death occurred, on the date stated above, at 1:05 P. m.

The CAUSE OF DEATH* was as follows:

Inoperable Carcinnoma of the Stomach

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) E. P. Greenawalt, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cemetery	Sept 6 1920

20 UNDERTAKER J. J. Moran

ADDRESS 3000 E. Balto St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46255 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46255

CERTIFICATE OF DEATH.

91

REGISTERED NO. 15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Pindell

(a) RESIDENCE. No. 1303 Fulton Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter ON

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Pindell

11 BIRTHPLACE OF FATHER (city or town) Anne Arundel Co., (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Hearn

13 BIRTHPLACE OF MOTHER (city or town) Howard Co., (State or country) Md.

14 Informant Hospital Records.
(Address) New City Hospital.

15 Filed SEP 4 - 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3, 1920

17 I HEREBY CERTIFY, That I attended deceased from August 23, 1920, to Sept. 3, 1920.
that I last saw him alive on September 3, 1920.
and that death occurred, on the date stated above, at 5:15 P. m.
The CAUSE OF DEATH* was as follows:

Arterio-sclerosis
(no cerebral hemorrhage)

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) V. G. Herman. M. D.

9/4/ 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Sept 6 1920

20 UNDERTAKER: Milton M. Fisher — ADDRESS: 1701 Broadway

—6-9-19—H. P. Co.—1000 Bks.

20.46256 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.46256

CERTIFICATE OF DEATH. + 45

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Y OF BALTIMORE: (No.) Johns Hopkins Hosp. (St.) 7 (WARD)

2-FULL NAME Franklin Waite

(a) RESIDENCE. No. Du Bois, Pa ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 29 1864

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	10	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor Leader

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Andrew Waite

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Hortencia Wilson

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Hospital Record
(Address) J. H. H.

15 Filed SEP 4 - 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4th 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 27, 1920, to Sept 4th, 1920, that I last saw him alive on Sept 4th, 1920, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Epigastrium.

? (duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Ovary

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/3/20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. D. Rumbaugh Jr. M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dubois Pa	9/4 1920
20 UNDERTAKER Jack Lewis	ADDRESS 1411 E Balto

—6-9-19—H. P. Co.—1000 Bks.

.46257 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.46257

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 110 N. Carrollton Ave. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Frederick Keller Jr.

(a) RESIDENCE. No. 110 N. Carrollton Ave. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	13	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George F. Keller Sr.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen V. Keller

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant George F. Keller Sr.
(Address) 110 N. Carrollton Ave.

15 Filed SEP 1 1920, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1918, to Sept 2, 1920, that I last saw him alive on Sept 2, 1920, and that death occurred, on the date stated above, at 12-30- P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

Well 2 yrs. ✓ mos. ✓ ds. (duration)

CONTRIBUTORY (Secondary) None (duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No By Phys Exam

What test confirmed diagnosis?

(Signed) Henry C. Kelly M. D.

, 19 (Address) 1263 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Sept 6" 1920

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 W. Balt. Street

ad 299

—6-9-19—H. P. Co.—1000 Bks.

946258 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 946258

CERTIFICATE OF DEATH. 61-801

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 1221 Cloverdale Rd. ST.) 13 WARD)

2-FULL NAME Howard Leigh Goodman

(a) RESIDENCE. No. 1221 Cloverdale Rd. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 4 mos 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word):

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 29/20

7 AGE — Years: — Months: 4 Days: 6 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) bld

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Louis Goodman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila. Pa.

12 MAIDEN NAME OF MOTHER Mildred Finie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Louis Goodman

(Address) 1221 Cloverdale Rd.

15 Filed SEP 5 — 1920 ROBERT F. BRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/4 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 25th, 1920, to Sept. 4th, 1920, that I last saw h[illegible] alive on Sept 3rd, 1920, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Acute Hydrocephalus

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry Goldberg, M. D.

9/4, 1920 (Address) 2210 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington Rd. DATE OF BURIAL: Sept 5 1920

20 UNDERTAKER: Jack Levin ADDRESS: 1411 E. Balto. St.

—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

246259

246259

61-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vergie Drane.

(a) RESIDENCE. NO. 474 S. Collington Ave. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: John Joseph Drane

7 DATE OF BIRTH (month, day, and year): Not known

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Help in laundry

(b) General nature of industry, business, or establishment in which employed (or employer): Laundry

(c) Name of employer: Elite Laundry

9 BIRTHPLACE (city or town) (State or country): Briar Branch Va.

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: John J. Drane

(Address): 474 S. Collington ave

15 Filed SEP 5 - 1920 19 ROBERT A. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1920, to Sept 4, 1920, that I last saw her alive on Sept 3, 1920, and that death occurred, on the date stated above, at 4:15 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis (epidemic)

(duration) indefinite — yrs. — mos. 10? ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) — yrs. — mos. ? ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) B. MacGowan. M. D.

(Address) Sydenham Hospital.

Sept 4 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cmetery	Sept 5 1920
20 UNDERTAKER: Urbain Cook	ADDRESS: 502 E North

—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046260

6260

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1925 Cecil Ave ST.: 9 WARD)

2-FULL NAME Charles William Heinz

(a) RESIDENCE. No. 1925 Cecil Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 10 mos. 6 ds. How long in U. S., if of foreign birth? 8 yrs. 10 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 6 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child at school

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Chas Wm Heinz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Henrietta Fricke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant (Address): Walter C. Bacon Baltimore Md

15 Filed SEP 5 - 1920, 19 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3 1920

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1920, to Sept. 3, 1920, that I last saw him alive on Sept 3, 1920, and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

Endo Carditis

(duration) about 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Walter C. Bacon, M. D.

9/4/20 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Sept 6 1920
20 UNDERTAKER	ADDRESS
William Cook	501 E Nat

946261

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

64 946261

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 28 W. 25th St. ST.: 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francina Wright.

(Residence in Baltimore: No. 28 W. 25th St. St.: 20 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, ~~MARRIED~~ ~~WIDOWED~~ OR DIVORCED (Write the word)
Female	White	Single

6-DATE OF BIRTH Feb. (Month) 14 (Day), 1837 (Year)

7-AGE 81 yrs. 6 mos. 15 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country) Howard Co. Maryland

PARENTS

10-NAME OF FATHER Joshua Holmes Wright

11-BIRTHPLACE OF FATHER (State or country) Montgomery Co. Md

12-MAIDEN NAME OF MOTHER Amanda E. Shipley

13-BIRTHPLACE OF MOTHER (State or country) Howard Co. Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Surratt Wright

(Address) 28. W. 25th St.

15 SEP 5 - 1920 ROBERT F. LEADER REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept. (Month) 4 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 26th, 1920, to Sept. 4th 1920, that I saw h er alive on Sept. 4th, 1920, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, paralysis

(Duration) ..... yrs. ..... mos. 10 ds

Contributory (SECONDARY) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. H. Rhoads. M. D.

Sept. 4th, 1920 (Address) 2404 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt Kondria Md | DATE OF BURIAL Sept 6, 1920

20-UNDERTAKER William Cook | ADDRESS 502 E North Ave

State CAUSE OF DEATH. See instructions on back. This is very important.

Dec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46262 + 40 2246262

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1514 Division St ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Ann M. Neff.

Residence in Baltimore: No. Union Protestant Infirmary St.; ..... yrs., ... mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED or DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan. 31, (Month) (Day) 1869 (Year)

7-AGE, 51 yrs. 7 mos. 4 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION: 037

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer) Housewife.

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Abner Myers

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania.

12-MAIDEN NAME OF MOTHER Sarah Snyder

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. K. L. Wink

(Address) Manchester Md.

15- SEP 5 - 1920 Filed....., 191.... ROBERT B. CRAUTER Registrar

BURIAL PERMIT ISSUED

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 5, (Month) (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 29 1920, to Sept 5 1920, that I saw h.r alive on Sept 5 1920, and that death occurred, on the date stated above, at 3.50 a.m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach.

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) J. W. Hammond Lippy M. D.

Sept 5, 1920. (Address) Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 10 ds. In the State ..... yrs. ..... mos. 10 ds.

Where was disease contracted, if not at place of death? Pennsylvania.

Former or usual residence Pennsylvania.

19-PLACE OF BURIAL OR REMOVAL, Hanover Penn. DATE OF BURIAL, Sept. 8th, 1920

20-UNDERTAKER Jacob Winkert & Son ADDRESS Manchester Md

046263 HEALTH DEPARTMENT—CITY OF BALTIMORE 046263.

CERTIFICATE OF DEATH.

64 REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Park Heights Ave + Clarks Lane ST.) (WARD) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Schley Haines

(Residence in Baltimore: No. Park Heights Ave + Clarks Lane St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, April (Month) 2 (Day), 1844 (Year)

7-AGE, 76 yrs. 5 mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Augusta Georgia

PARENTS.

10-NAME OF FATHER, William Haines

11-BIRTHPLACE OF FATHER (State or Country), New Jersey

12-MAIDEN NAME OF MOTHER Mary Emma Schley

13-BIRTHPLACE OF MOTHER (State or Country), Augusta Ga.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Emma Schley Carpenter

(Address) Park Heights + Clarks Lane

15- Filed SEP 5 - 1920 191.. ROBERT F. KRAUTER Registrar

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 3 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) John Morrison M. D.

Coroner

Sept 3 1920 (Address) 3627 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Augusta Georgia

DATE OF BURIAL, Sept 6, 1920

20-UNDERTAKER Chas. L. Black

ADDRESS 742 W. North Ave

important. See instructions on

...c.—8-24-14—M. & T.—2000 Bks.

46264

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046264

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO. C.....

ITY OF BALTIMORE: (No. 311 S. Madeira ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jos Rozewski —

Residence in Baltimore: No. 311 S. Madeira St.; ....yrs., 6 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, January 6th, 1913
(Month) (Day) (Year)

7-AGE. ....yrs. 6 mos. 29 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Stanislaus Rajewski.

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Leonora Polanowska.

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanislaus Rajewski.

(Address) 311 S. Madeira St.

15- SEP 5 - 1920 ROBERT B BRAUER

Filed....., 191.... Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 4 —, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 30 1920, to Aug 30 1920, that I saw h— alive on Aug 30 — 1920, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis —

(Duration) ....yrs. 1½ mos. ....da.

CONTRIBUTORY (Secondary) General Debility —

(Duration) ....yrs. ....mos. 12 da.

(Signed) Robt B Brauer M. D.

Sept. 4, 1920 (Address) 125 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Rosary Cem

DATE OF BURIAL. Sept 6, 1920.

20-UNDERTAKER M. Sadowski

ADDRESS 905 S. Ann St

cc.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46265

46265

CERTIFICATE OF DEATH. X 82

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Notre Dame Convent ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Irene Wittmann

Residence in Baltimore: No. Crespinth St & Cathedral Ave St.; ....yrs. 1 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, January 20, 1869 (Month) (Day) (Year)

7-AGE, 51 yrs. 7 mos. 13 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Irondequoit, N. Y.

PARENTS.

10-NAME OF FATHER, John Wittmann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catharine Wiesner

13-BIRTHPLACE OF MOTHER (State or Country), Rochester N. Y

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister M. Dismas

(Address) Notre Dame Crespinth St

15-

Filed SEP 5 - 1920 191.. ROBERT B KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 2, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 7 1920, to Sept 2 1920, that I saw her alive on Sept 2 1920, and that death occurred, on the date stated above, at 11.20 a.m.

The CAUSE OF DEATH* was as follows:

Thrombosis Middle Cerebral artery (Left)

(Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Endarteritis Obliterans

(Duration) ....yrs. unknown mos. ....ds.

(Signed) Wm. de Graaf M. D.

Sept 3, 1920 (Address) 1038 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence New York

19-PLACE OF BURIAL OR REMOVAL, Natch Cliff Md

DATE OF BURIAL, Sept 6, 1920

20-UNDERTAKER Frank C. Fink

ADDRESS 910 N. Gay St.

8-9-19—H. P. Co.—1000 Bks.

2568

2046266

HEALTH DEPARTMENT—CITY OF BALTIMORE

2046266

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Y OF BALTIMORE: (a) No. Johns Hopkins Hosp ST.: 7 WARD)

2-FULL NAME Lillian Busick.

(a) RESIDENCE. NO. 539 E. Eager st. Baltimore Md. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Dec. 25-1919

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		7.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Busick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elsie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address) Johns Hopkins Hospital

15 Filed SEP 5 - 1920, 19 ROBERT A. BRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 9 ~~Sept~~ +, 19 20, to Sept 4, 19 20,

that I last saw h. alive on Sept 4, 19 20,

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Diarrhea

(duration) yrs. mos. 35 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilbert E Davison, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem

DATE OF BURIAL Sept 6 1920

20 UNDERTAKER Joseph Abrams

ADDRESS [redacted]

6-9-19—H. P. Co.—1000 Bks.

Transitory

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46267 98 D46267

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2207 Division St.: 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifton Fauntleroy

(a) RESIDENCE. No. 2207 Division St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 22, 1887

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
33	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Musician 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Henry Fauntleroy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Lucinda Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Isabel Fauntleroy 1835 Division St

15 Filed SEP 5 - 1920 19

ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1920, to Sept. 2, 1920, that I last saw him alive on Sept. 1, 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

General Prostration brought on by Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. Hawkins M. D.

9/3, 1920 (Address) 1216 Druid Hill Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	SEP 5 1920
20 UNDERTAKER: JAMES H. DENNIS	ADDRESS: 1303 PRESTMAN ST.

1046268 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046268

CERTIFICATE OF DEATH.

REGISTERED NO. C 8

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 21 Cereal St. Curtis Bay ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Brzezinski.

(Residence in Baltimore: No. 21 Cereal St. Curtis Bay. St.: yrs., 1 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, July 30th. 1920., 1 (Month) (Day) (Year)

7-AGE, ---yrs. 1 mos. 5 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None. 000
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Brzezinski.

11-BIRTHPLACE OF FATHER (State or Country). Poland.

12-MAIDEN NAME OF MOTHER Elizabeth Goleinboski.

13-BIRTHPLACE OF MOTHER (State or Country). Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Brzezinski. (mother)

(Address) 21 Cereal St. Curtis Bay.

15- SEP 5 - 1920 ROBERT P. LEUTER
Filed ... 191.. Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 4th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Whooping-cough.

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) ...

(Duration) ...yrs. ...mos. ...ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Sept. 4, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Holy Cross R.C. DATE OF BURIAL, Sept 5, 1920

20-UNDERTAKER Wm Hallowell ADDRESS 160 Cedar

Important. Sign with ink.

cc.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46269 104 2946269

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1155 E. Lombard ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Depszis

Residence in Baltimore: No. 1155 E. Lombard St.; ..... yrs., 1 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March 28, 1920 (Month) (Day) (Year)

7-AGE, ... yrs. 5 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) " "

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Stanley Depszis

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER mary Ratzis

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanley Depszis

(Address) 1155 E Lombard St

15- Filed SEP 5 - 1920 ROBERT E KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep. 4, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sep. 2, 1920, to Sep. 4, 1920, that I saw her alive on Sept 3, 1920, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Ileo colitis

(Duration) .....yrs. .....mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) Eugene L. Pressman M. D.

Sep. 4, 1920 (Address) 2314 E. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Sept 5, 1920

20-UNDERTAKER Wm Fallsows & Son

ADDRESS 1111 Eastern Ave

—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046270 104 1046270

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3043 Elliott St.: 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Przywara

(a) RESIDENCE. No. 3043 Elliott St., 1 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 24 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas Przywara

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Sophie Holewinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Sophie Przywara (Address) 3043 Elliott

15 Filed SEP 5 - 1920 ROBERT P. ELLIOTT Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1920 to Sept 4, 1920, that I last saw h[im] alive on Sept 2, 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis (duration) ... yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Congenital Debility (duration) 1 yrs. 8 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M J McAvoy, M. D.

9/4 1920 (Address) 839 S. Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Sep 5 1920

20 UNDERTAKER Stephen J. Fitzpatrick ADDRESS 1005 S. Kenwood

—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046271

46271

151

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.) 205 Lawn Ave (ST.) 12 (WARD)

2-FULL NAME Baby Royston

(a) RESIDENCE. NO. 205 Lawn Ave St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Infant

a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Sept. 3, 1920

7 AGE Years Months Days 1 If LESS than 1 day 12 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles R. Royston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co. Md.

12 MAIDEN NAME OF MOTHER Nellie Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co. Md.

14 Informant Chas. R. Royston

(Address) 206 Gaston Ave.

15 Filed SEP 5 — 1920 ROBERT J. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1920, to Sept. 4, 1920, that I last saw h.er alive on Sept. 4, 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity (5 mo.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Machen, M. D.

, 19 (Address) 4119 Falls Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden

DATE OF BURIAL Sept 6 192

20 UNDERTAKER E. LeRoy Stubbs

ADDRESS 1[illegible] E North Ave

—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046272

1046272

CERTIFICATE OF DEATH.

+ 74

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp. ST.: (WARD) 7

2-FULL NAME Robert Dickhoff.

(a) RESIDENCE. NO. 819 State St. Schenectady N.Y. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State) New York.

Length of residence in city or town where death occurred yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 14 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk.

(b) General nature of Industry, business, or establishment in which employed (or employer) D09

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Bernhart Dickhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosalie Sommer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Hospital Record J. H. H.

15 Filed SEP 5 - 1920 19 ROBERT B. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 - 1920

17 I HEREBY CERTIFY, That I attended deceased from July 21 1920, to Sept 5 1920, that I last saw him alive on Sept 5 1920, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/1/20

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Hunter H. Tiernay Jr, M. D.

, 19 (Address) 1 Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schenectady N.Y.

DATE OF BURIAL Sept 7 1920

20 UNDERTAKER Geo J Smith

ADDRESS 1000 Fayette

c.—6-9-19—H. P. Co.—1000 Bks.

46273 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 46273

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

REGISTERED No.....

ITY OF BALTIMORE: (No. 1742 Ashland Ave ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Alverta Gaskins

(a) RESIDENCE. No. 1742 Ashland ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 31 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — none —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Arthur Gaskins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Marie Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Arthur Gaskins

(Address) 1742 Ashland ave

15 Filed SEP 6-1920 ROBERT A LAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3rd 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st 1920, to Sept 3rd 1920, that I last saw h[e] alive on Sept 3rd 1920, and that death occurred, on the date stated above, at 6.10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Congestion

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J Finsorley, M. D.

, 19 (Address) 908 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Sept 6th 1920

20 UNDERTAKER Chas G Bailey ADDRESS 142 Jefferson st

6-9-1[illegible]—H. P. Co.—1000 Bks.

OVER

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046274

1046274

CERTIFICATE OF DEATH.

X 45

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Y OF BALTIMORE: (No. Johns Hopkins Hosp ST.: Ward 9 Ward Pablo Rodriguez Hospital a.o.u.) WARD 7

2-FULL NAME John Iesick

(a) RESIDENCE. NO Havana Cuba ST., WARD Havana Cuba

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Jan 17 1865

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cuba (State or country)

PARENTS

10 NAME OF FATHER John Iesick

11 BIRTHPLACE OF FATHER (city or town) Spain (State or country)

12 MAIDEN NAME OF MOTHER Agueda Lopez

13 BIRTHPLACE OF MOTHER (city or town) Spain (State or country)

14 Informant Hospital Record (Address) J. H. H.

15 Date Received SEP 6 - 1920 ROBERT [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4th 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Sept 4th 1920, that I last saw h[illegible] alive on Sept 4th 1920, and that death occurred, on the date stated above, at 6.48 a m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis (Uremia)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of Prostate

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Havana, Cuba

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood urea

(Signed) H. A. Frontz, M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Havana Cuba	Sept 7 1920

20 UNDERTAKER — ADDRESS

Wm C. Black 927 N. Broadway

[Approved by t

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fireman, etc.
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"Tumor"

ICES OF
OH M. YOUNG
M. A. FRONTZ
. C. COLSTON

JAMES BUCHANAN BRADY UROLOGICAL INSTITUTE
DEPARTMENT OF UROLOGY JOHNS HOPKINS UNIVERSITY AND HOSPITAL
NORTH BROADWAY, BALTIMORE, MD.

October 30, 1920.

TO WHOM IT MAY CONCERN:-

This is to certify that on September 4, 1920, Ursulo Juan Pablo Usich Y Llopiz died in the Johns Hopkins Hospital. His death certificate No. 46274 is made out in the name of John Usich. This is the same individual as named above. I authorize the changing of the certificate to the correct name, Ursulo Juan Pablo Usich Y Llopiz.

WAP-L.

W. A. Frontz, M.D.

Fannie Lee Block
Notary Public

c.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46275 — 2046275

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 W Mulberry St. ST.; 18 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L Lane

Residence in Baltimore: No. 919 W Mulberry St.; 16 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Married

6-DATE OF BIRTH, June 22, 1851 (Month) (Day) (Year)

7-AGE, 69 yrs. 2 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

837

9-BIRTHPLACE, (State or Country) Gettysburg Pa

PARENTS.

10-NAME OF FATHER, John Staub

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine M. Codore

13-BIRTHPLACE OF MOTHER (State or Country), France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L Lane

(Address) 919 W Mulberry

15- Filed SEP 6- 1920, 191... ROBERT P KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 3, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 25, 1920, to Sept. 3, 1920, that I saw her alive on Sept. 3, 1920, and that death occurred, on the date stated above, at 8 a, m.

The CAUSE OF DEATH* was as follows:

Bronchial asthma (Chronic) 1 year
Cardiac Insufficiency
about 20 years
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dyspepsia Insomnia 1 year
Intermittent Hemorrhoids
(Duration) yrs. mos. ds.

(Signed) Orville M Codore M. D.

Sept. 6, 1920 (Address) 1407 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, 9—6—, 1920

20-UNDERTAKER H. C Brauning Son — ADDRESS 517 N Schroeder St

c.—6-9-19—H. P. Co.—1000 Bks.

46276

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 46276

REGISTERED NO.

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 413 E Federal ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Bundy

(a) RESIDENCE. NO. 413 E Federal ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): x x Unknown

7 AGE: Years 70 | Months x | Days x | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Hochschild Co's

9 BIRTHPLACE (city or town) (State or country): [illegible] Va

PARENTS

10 NAME OF FATHER: Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Dont Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Hodges Effs (Address) 413 E Federal St

15 Filed SEP 6 - 1920

16 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/4/ 19 20

17 I HEREBY CERTIFY, That I attended deceased from 9/1/ 19 20 to 9/4/ 19 20

that I last saw h[illegible] alive on 9/4/20 19 and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular Disease

CONTRIBUTORY (Secondary): Sub acute Nephritis (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Guy Bowley, M. D.

19 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: 9/6 1920

20 UNDERTAKER: John H Owens

ADDRESS: S-38 Dolphin

...—6-9-19—H. P. Co.—1000 Bks.

46277 HEALTH DEPARTMENT—CITY OF BALTIMORE 1946277

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

TY OF BALTIMORE: NO. 3125 Druid avenue ST.; WARD)

2-FULL NAME George Henry Clark.

(a) RESIDENCE. NO. 3125 Druid ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Same mos. ds. How long in U. S., if of foreign birth? Same yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Birdie E. Clark

DATE OF BIRTH (month, day, and year) Jan 18 1871

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
49		7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber, Gas & Steam Fitter

(b) General nature of industry, business, or establishment in which employed (or employer) Master Plumber

(c) Name of employer Same.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Birdie Mc Cleary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) William E. Clark 3125 Druid ave

15 Filed SEP 6 - 1920 ROBERT F. CARTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) Sept 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 2 1920 to Sept 2 1920

that I last saw h[illegible] alive on Sept 2 1920

and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Heart Exhaustion

(duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) X yrs. 6 mos. X ds.

18 Where was disease contracted if not at place of death? Same.

Did an operation precede death? No Date of No

Was there an autopsy? yes

What test confirmed diagnosis? Yes

(Signed) Jas L. Mc[illegible] M. D.

19 (Address) 24 So 20 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Sept 6 1920

20 UNDERTAKER H. Sander Sons

ADDRESS 1710 Fleet St

046278 HEALTH DEPARTMENT—CITY OF BALTIMORE 046278

CERTIFICATE OF DEATH.

175-001

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Asylum Hospital ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Geo. E. Brooks.

(Residence in Baltimore: No. 1307 N. Bonds St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, June 30, 1875
(Month) (Day) (Year)

7-AGE, 45 yrs. 2 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): Employee

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William M. Brooks

11-BIRTHPLACE OF FATHER (State or Country), Canada

12-MAIDEN NAME OF MOTHER Susan R. Cole

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susan R. Brooks

(Address) 1413 N. High Broadway

15-SEP 6- 1920 Filed....., 191.... ROBERT B KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 3, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
Cerebral Fracture

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) ....yrs. ....mos. ....ds.

(Signed) William Wades M. D.
(Coroner.)

9/4/20 191.. (Address) 143 N. Bond

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery — DATE OF BURIAL, Sept. 6, 1920

20-UNDERTAKER John B. Spence — ADDRESS 1325 N. London St.

Important. See Instructions

Spec.—5-19-13—M. & T.—500 Bks.

046279

HEALTH DEPARTMENT—CITY OF BALTIMORE

046279

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 545-23 rd ½ ST.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Reubensperger

Residence in Baltimore: No. same St. 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Sept. 20, 1845. (Month) (Day) (Year)

7-AGE, 74 yrs. 11 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 087

9-BIRTHPLACE, (State or Country), Davis N. Va.

PARENTS.

10-NAME OF FATHER, Amer L. Lebensperger

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Mary Gromis

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Lebensperger.

(Address) 545 E 23rd St.

15-Filed SEP 6- 1920, 191.... ROBERT B BRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9/2, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/1, 1917, to 9/2, 1920, that I saw her alive on 9/2 1920, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Duration

(Duration) mos. ds.

(Signed) H. Stanley Forsyth M. D.

9/6, 1920 (Address) 1900 St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park. DATE OF BURIAL, Sept. 6, 1920

20-UNDERTAKER John J. Fahey, Son ADDRESS 1318 Light St.

6-9-19—H. P. Co.—1000 Bks.

0.46280

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046280

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 Boyd St. ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine Murray

(a) RESIDENCE. NO. 1005 Boyd St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov, 16, 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Harrie Murray.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Mary Carrigan.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Jersey.

14 Informant (Address): 1005 Boyd St. Mr Harrie Murray.

15 FILED SEP 6 - 1920 ROBERT P. PRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4 1920.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to Sept 4, 1920, that I last saw h[illegible] alive on Sept 3, 1920, and that death occurred, on the date stated above, at 6 35 a m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C A Refschneider M. D.

9/5, 1920 (Address) 340 S. East Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery.	Sept 6. 1920
20 UNDERTAKER J.J.Cowan & Son.	ADDRESS 901 Hollins

cc.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46281 37 D46281

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4206 Belloview ave St.; 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanley Dever Pagg

Residence in Baltimore: No. 4206 Belloview ave St., 43 yrs., 1 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED,~~ OR DIVORCED, (*Write* the word.) Divorced

6-DATE OF BIRTH, July (Month) 14th (Day), 1877 (Year)

7-AGE, 43 yrs. 1 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Insurance
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Dr. F. P. Pagg

11-BIRTHPLACE OF FATHER (State or Country), Md -

12-MAIDEN NAME OF MOTHER Annie Dever

13-BIRTHPLACE OF MOTHER (State or Country), Md -

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. P. Pagg

(Address) 4206 Belloview ave

15-
Filed SEP 6- 1920, 191.....
ROBERT E KRAUTER
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 4th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1919, to Sept 4th 1920, that I saw him alive on Sept 2nd 1920, and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

General Paresis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tertiary Syphilis

(Duration) yrs. mos. ds.

(Signed) Eugene Douglas M. D.

Sept. 6., 1920 (Address) 830 W North ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Centerville Md

DATE OF BURIAL, Sept 7th, 1920

20-UNDERTAKER John O. Mitchell

ADDRESS 1201 W. Fayette

ec.—8-24-14—M. & T.—2000 Bks.

46282 HEALTH DEPARTMENT—CITY OF BALTIMORE V 46282

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 128 N Calhoun St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William T. Wallis Gibney

Residence in Baltimore: No. 128 N Calhoun St.; 62 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Jan 17, 1858
(Month) (Day) (Year)

7-AGE, 62 yrs. 7 mos. 17 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, George J. Gibney

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Mary A Bunting

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary V. Mitchell

(Address) 128 N Calhoun

15- Filed SEP 6 - 1920, 191.... ROBERT B BRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 3, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 18th 1920, to Sept 3 1920, that I saw him alive on Aug 28 1920, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows: MW

Hemiplegia

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

..... (Duration) 1½ yrs. ..... mos. ..... ds.

(Signed) Marshall D. Smith M. D.

Sept 5, 191.. (Address) 11 E N Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem | DATE OF BURIAL, Sept 7, 1920

20-UNDERTAKER John C. Mitchell | ADDRESS 701 W Fayette

—6-9-19—H. P. Co.—1000 Bks.

946283

HEALTH DEPARTMENT—CITY OF BALTIMORE

946283

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Elgin near Pa ave St.: 15 Ward) near Cliffin Ave 40 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura L Teal

(a) RESIDENCE. No. Elgin near Pa ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of John Teal

6 DATE OF BIRTH (month, day, and year) June 19 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Enoch Hiser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Anna Hiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant John Teal
(Address) Elgin near Pa ave

15 Filed SEP 6 - 1920 19 ROBERT F. LEASTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1919, to Sept 5, 1920, that I last saw h[illegible] alive on Sept 4, 1920, and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Allen, M. D.

9/6/20 (Address) 2757 Whitelock ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	Sept 7 1920
20 UNDERTAKER	ADDRESS
W M Routson	2238 W Saratoga

6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46284 46284 104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 308 S. Chester ST.: V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Emmett Sparrow

(a) RESIDENCE. No. 308 S. Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Infant. 308

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jas. Sparrow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Minnie McDonough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Jas. Sparrow 308 S. Chester.

15 Filed SEP 6 - 1920 19 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1920, to Sept 4, 1920

that I last saw him alive on Sept 4, 1920

and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Illeo-Colitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY, (Secondary) Congenital Weakness

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Joseph L. Valentine M.D.

Sept 6 1920 (Address) 2 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Sept 6 1920

20 UNDERTAKER John A. Moran ADDRESS 3000 E. Baltimore St

6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151

1946285

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 N Washington St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph C Heid

(a) RESIDENCE. NO. 500 N Washington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 5 '20

7 AGE: Years | Months | Days | If LESS than 1 day 2 hrs. or min.

8 OCCUPATION OF DECEASED: None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. Balto

PARENTS

10 NAME OF FATHER Joseph C Heid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Maria Barbara Dept 6 '20

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant (Address) Joseph C Heid Sr 500 N Washington Ave

15 Filed SEP 6 - 1920 ROBERT B. LAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1920, to Sept 5, 1920, that I last saw him alive on Sept 5, 1920, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Congenital Debility 3 hours

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

Exhaustion 24 hr

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. P. K. Campbell M. D.

(Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart. | DATE OF BURIAL: Sept 6 1920

20 UNDERTAKER: Jos L Dent Fayette Lexington Ave | ADDRESS

6-9-19—H. P. Co.—1000 Bks.

Gross

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D46286

D46286

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 McElderry ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Grass

(a) RESIDENCE. NO. 1423 McElderry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colrd	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Grass

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labarer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Grass

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sarah Grass
(Address) 1423 McElderry St

15 Filed SEP 6 - 1920 ROBERT J. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 27, 1920, to Sept. 3, 1920, that I last saw him alive on Sept. 3, 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. J. Green, M. D.

9-4 1920 (Address) 120 1/2 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Sept 6 1920

20 UNDERTAKER R B Gross ADDRESS 1405 McElderry

HEALTH DEPARTMENT—CITY OF BALTIMORE

46287 — 1920 — 2046287

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6004 Bellona Ave ST.; 27 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellenora F Brewer

Residence in Baltimore: No. 6004 Bellona Ave St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, June (Month) 30 (Day), 1879 (Year)

7-AGE, 41 yrs. 2 mos. 5 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frank Woestman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Betty Kerckhoff

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Emma Andrae

(Address) 6004 Bellona Ave

15-

Filed SEP 6- 1920, 191.... ROBERT J. KRAUTER Registrar.

Burial Permit Issued

Dr Gittl Md ave near 25th st

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 5th (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 5 1920, to Sept 5 1920, that I saw h[illegible] alive on Sept 5 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 2 yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(Duration) .... yrs. .... mos. .... ds.

(Signed) Frank W Gittl M. D.

Sept 6th, 1920. (Address) 2431 Mary Land Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hagerstown Md. DATE OF BURIAL, Sept 7, 1920

20-UNDERTAKER Chas. J. Black ADDRESS 742 W North ave

ec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46288 V 2046288

46288

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. Harvard A. Kelly Hosp. St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Genoa V. Crawford.

Residence in Baltimore: No. 1418 Eutaw Place. St.; ....yrs.,....mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct (Month) 25 (Day), 1903 (Year)

7-AGE, 16 yrs. 10 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Student
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Jeays W. Virginia

PARENTS.

10-NAME OF FATHER, Napoleon B. Crawford

11-BIRTHPLACE OF FATHER (State or Country), W. Virginia

12-MAIDEN NAME OF MOTHER Ida E. Dodd

13-BIRTHPLACE OF MOTHER (State or Country), W. Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Napoleon B. Crawford

(Address) Huntingdon W. Va

15-
Filed SEP 6 - 1920 191.....

ROBERT B KRAUTER
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 5 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 27 1920, to Sept. 5 1920, that I saw her alive on Sept. 5. 1920, and that death occurred, on the date stated above, at 7 45 P.m.

The CAUSE OF DEATH* was as follows:

Lympho-sarcoma

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Arthur C. Primrose M. D.

Sept. 5, 1920 (Address) 1418 Eutaw Place.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 10 ds. In the State ....yrs. ....mos. 10 ds.

Where was disease contracted, if not at place of death? Huntington W Va.

Former or usual residence Huntington. W. Va.

19-PLACE OF BURIAL OR REMOVAL, Huntington W. Va

DATE OF BURIAL, Sept. 6., 1920

20-UNDERTAKER Chas. G. Black

ADDRESS 742 W North Ave

—6-9-19—H. P. Co.—1000 Bks.

46289 HEALTH DEPARTMENT—CITY OF BALTIMORE 113 2046289

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3775 Kossuth ST.; 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Ann Smith

(a) RESIDENCE. NO. 3775 Kossuth ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 6 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: George F. Smith

6 DATE OF BIRTH (month, day, and year): Feb 20th 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Custer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Teresa Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harrisburg

14 Informant: Mary T. Clark (Address) 3775 Kossuth St.

15 Filed SEP 6 - 1920 ROBERT A. EICHER Registrar

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 5. 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20 1920, to Sept. 5. 1920, that I last saw her alive on Sept. 4. 1920 and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver - (atrophic)

(duration) yrs. 6. mos.

CONTRIBUTORY (Secondary) Anemia, Malnutrition

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No -

What test confirmed diagnosis? Clinical

(Signed) M C Fruiniger M.D. M. D.

9-5 1920 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Sept 7th 1920
20 UNDERTAKER	ADDRESS
Patrick A. Hannon	1911 N. Lombard St.

46290

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

H 2 D46290

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2512 N. Fairmount Av ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Mathison

(Residence in Baltimore: No. 2512 N Fairmount Av. St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female.	White	widow

6-DATE OF BIRTH November 19 1881 (Month) (Day) (Year)

7-AGE 38 yrs. 9 mos. 15 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer): at Home. 69

9-BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10-NAME OF FATHER: Francis A Krein

11-BIRTHPLACE OF FATHER (State or country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Annie Huber

13-BIRTHPLACE OF MOTHER (State or country): Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John F. Krein

(Address) 2512 N. Fairmount Av

15 SEP 6 - 1920 Filed ..... 191 .....

ROBERT J. REUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH September 4 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 25, 1919, to, September 4 1920, that I saw h[illegible] alive on September 3 1920, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus.

(Duration) 1 yrs 1 mos. 10 ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs ..... mos. ..... ds.

(Signed) Thos F. Stevens M. D.

Sept. 4 1920 (Address) 2866 Hanford Rd.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: Sept 9 1920

20-UNDERTAKER: Penny Storck Sty ADDRESS: 130 E Eager

—6-9-19—H. P. Co.—1000 Bks.

046291

HEALTH DEPARTMENT—CITY OF BALTIMORE

046291

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. James St. near 6th ST.: Morrell Park 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Ernest Grace

(a) RESIDENCE. No. James St near 6th ST.: Morrell Park WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: single

6 DATE OF BIRTH (month, day, and year): Oct. 12 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Electrical Helper

(b) General nature of industry, business, or establishment in which employed (or employer): West End Service

(c) Name of employer: Station Ford Repairs

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm E. Grace

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Ida B. Pfeffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co Md

14 Informant: James A Shuster (Address) Morrell Park

15 Filed SEP 6 - 1920 ROBERT B KRAUTER Registrar BRIAN FARRELL Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Feby 1, 1920, to Sept 4, 1920, that I last saw h in alive on Sept 3, 1920, and that death occurred, on the date stated above, at 5-40 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo S McKieffer, M. D.

Sept 6, 1920 (Address) Morrell Park Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept. 7. 1920
20 UNDERTAKER: Jas B Cook	ADDRESS: 1003 W Balto

ec.—8-24-14—M. & T.—2000 Bks.

46292

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D46292

REGISTERED NO. C 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 881 N. Lombard ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Alice E. Dickinson,

Residence in Baltimore: No. 881 N. Lombard St. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) ....., 1..... (Day) (Year)

7-AGE, 60 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, William M. Wilson,

11-BIRTHPLACE OF FATHER (State or Country) Lancaster, Pa

12-MAIDEN NAME OF MOTHER, Harriet V. League

13-BIRTHPLACE OF MOTHER (State or Country) Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Edw. Wilson,

(Address) Union Class Track, P.O.

15-

Filed SEP 6- 1920 191.... ROBERT B KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 5th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 1918, to Sept 5 1920, that I saw her alive on Sept 5. 1920, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis.

..... (Duration) 3 yrs. ....mos. ....ds.

CONTRIBUTORY. —
(Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Chas. H. Parker M. D.

9/5/20, 191... (Address) 888 N. Lomb. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Sept. 8..., 1920

20-UNDERTAKER J. B. Cook — ADDRESS 1003 W. Balto St.

...—6-9-19—H. P. Co.—1000 Blks.

1046293

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046293

105

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 543 West Lafayette Ave.

CITY OF BALTIMORE: (NO.) Balto. Md. ST.: ( ) WARD: (17)

2-FULL NAME Emerson Richardson

(a) RESIDENCE NO. 543 W Lafayette ST., WARD.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos ds

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) —— 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(h) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Amberland Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen B. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Helen B. Smith

(Address) 543 W. Lafayette ave

15 SEP 6- 1920 BOWMAN REUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 20.

17 I HEREBY CERTIFY, That I attended deceased from Sept 3 , 1920, to Sept 5 , 1920, that I last saw him alive on Sept 4 , 1920, and that death occurred, on the date stated above, at 7.0 a m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) ..... M. D.

, 19 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	Sept 7th 20
20 UNDERTAKER	ADDRESS
Samuel W. Chase-son	1400 Argon

D46294 HEALTH DEPARTMENT--CITY OF BALTIMORE D46294

CERTIFICATE OF DEATH 28

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 806 Keyworth av ST. 15 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Frank L. Hancock

(Residence in Baltimore: No. 806 Keyworth av St. 57 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, ~~MARRIED~~ ~~WIDOWED~~ OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: April 24, 1859 (Month) (Day) (Year)

7 AGE: 61 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Anne Arundel Co Md

PARENTS

10 NAME OF FATHER: Samuel Hancock

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Louise Williams

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Elles

(Address) 806 Keyworth

15. SEP 6- 1920 ROBERT J. REUTER Burial Permit REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 3 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to, Sept 2 1920, that I saw him alive on Sept 2, 1920, and that death occurred, on the date stated above, at 40 m.

The CAUSE OF DEATH* was as follows:

Abscess of Lung
Pleurisy with Effusion
(Duration) ..... yrs. 3 mos. ..... ds.

Contributory (SECONDARY) Myocarditis
(Duration) 3 yrs. ..... mos. ..... ds.

(Signed), Emmit E. Magers M. D.

Sept 4, 1920. (Address) 8 E. Eager St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: CEDAR HILL. DATE OF BURIAL: SEP 6- 1920

20 UNDERTAKER: JOHN F. DENNY ADDRESS: 716 LIGHT ST.

Here state if anything is very important. See instructions on back of this sheet.

1046295 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046295

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1804 Maryland Ave ST. 17 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse McLain

(Residence in Baltimore: No. 1804 Maryland Ave St. (yrs. 38 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col'd	Married

6-DATE OF BIRTH, unknown (Month), (Day), 1870 (Year)

7-AGE, about 50 yrs ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), N. C.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Mary unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Jesse McLain

(Address) 1804 Md Ave

15- Filed SEP 6-, 1920 ROBERT B BRAUTER Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 4 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (~~Inquest, autopsy or inquiry.~~) thereon and from the evidence obtained by said (Inquest, au-~~topsy or~~ inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular heart

3 mos. or more (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner) Sept 5, 1920 (Address) 1029 Bradley

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Emy — DATE OF BURIAL, Sept 8, 1920

20-UNDERTAKER Mrs Robt A Elliott — ADDRESS 1725 Maryland Ave

—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1046296 ✓ 1046296

1046296

1-PLACE OF DEATH

REGISTERED NO. 14

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 5th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mc Kinley Royster.

(a) RESIDENCE. NO. 515 N. Eden St Baltimore Md WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Nov. 18 1919.

AGE: Years — Months: 9. — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): Child

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Luther Royster.

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Minnie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Hospital Record J. H. H.

(Address)

15 SEP 6 - 1920 ROBERT E. LEE, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 27 - 20, 19..., to Sept. 4, 1920,

that I last saw h. alive on Sept. 4 - , 1920,

and that death occurred, on the date stated above, at 11 a - m.

The CAUSE OF DEATH* was as follows:

Dysentery

OVER

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wilbur C. Davison, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: Sept-6 1920

20 UNDERTAKER: Mrs Robert A Elliott

ADDRESS 1725 Ashland Ave

ec.—8-24-14—M. & T.—2000 Bks.

46297

HEALTH DEPARTMENT—CITY OF BALTIMORE

46297

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. The Howard A. Kelly Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr. Henry P. Murphy.

Residence in Baltimore: No. 1418 Eutaw Place St.; yrs., mos. 32 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1863.
(Month) (Day) (Year)

7-AGE, 57 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lumber Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): D.45

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER. Patricke Murphy

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Bridget Murphy

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna E. Murphy

(Address) Hinman Rd Lockport N.Y.

15- SEP 7- 1920 ROBERT F. LEESTER

Filed....., 191.... Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. September 6th, 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1920, to Sept. 5 1920, that I saw h[im] alive on Sept 5 1920., and that death occurred, on the date stated above, at 1.00 a.m.

The CAUSE OF DEATH* was as follows:

Malignant Papilloma of Bladder

? ? ?

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) Arthur C. Primrose M. D.

Sept. 6, 1920. (Address) 1418 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ✓ yrs. ✓ mos. 32 ds. In the State ✓ yrs. ✓ mos. 32 ds.

Where was disease contracted, if not at place of death? ✓

Former or usual residence Hinman Rd. Lockport. N. Y.

19-PLACE OF BURIAL OR REMOVAL. Hinman Rd Lockport N.Y. DATE OF BURIAL. Sept. 6..., 1920

20-UNDERTAKER Martin Fahey & Sons ADDRESS 827 W. North Ave

—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46298 4046298

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. 3326 Gwynns Ave. WARD 17)

2-FULL NAME John P. Lacey

(a) RESIDENCE NO. 3326 Gwynns Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Eighteen mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Lacey

7 DATE OF BIRTH (month, day, and year) April 7 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	47.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Grocerios. 534

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER William Lacey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margt Lambert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant (Address) Mary E Lacey 3326 Gwynnsbrook Ave.

15 Filed SEP 7 - 1920 ROBERT A KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3 1920

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1920, to Sept 3, 1920, that I last saw h[im] alive on Sept 3, 1920, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach & Liver

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhages from bowels & kidneys

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Autopsy

(Signed) Lady D'Ogrotan, M. D.

Sept 6, 1920 (Address) 5-E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Grave DATE OF BURIAL Sept 7 1920

20 UNDERTAKER E. A. Widefield ADDRESS 2 Green Mt Ave

6-9-19—H. P. Co.—1000 Eks.

46299

HEALTH DEPARTMENT—CITY OF BALTIMORE

46299

CERTIFICATE OF DEATH.

46299

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Y OF BALTIMORE: (NO. 1235 S. Decker ST.: Ash WARD)

2-FULL NAME Walter Korezmowski

(a) RESIDENCE. NO. 1235 S. Decker Ave ST.: 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. —

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) June 16, 1919

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	2	20	

6 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Walter Korezmowski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Catherine Zehowska

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Walter Korezmowski (Address) 1235 S Decker Ave

15 Filed SEP 7- 1920 ROBERT B. HEUISLER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 28 1920 to Sept 6 1920, that I last saw him alive on Sept 6 1920, and that death occurred, on the date stated above, at 11 04 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) William J. Rosch, M. D.

(Address) 801 N Decker Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Sept 6 1920
20 UNDERTAKER	ADDRESS
Stephen J Trakowski	1002 S Ann

—6-9-19—H. P. Co.—1000 Bks.

46300

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 D46300

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Y OF BALTIMORE: (No 1137 Etting ST.: 17 WARD)

2-FULL NAME Benjamin Brown

(a) RESIDENCE. No. 1137 Etting ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Lottie Brown

6 DATE OF BIRTH (month, day, and year) Jan - 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	31	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 078

(b) General nature of industry, business, or establishment in which employed (or employer) Salesroom (typewriter)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Solomon Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Md

12 MAIDEN NAME OF MOTHER Rachael Sutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eastern Shore Md.

14 Informant (Address) Lottie Brown 1109 Etting St.

Filed SEP 7 - 1920 WILLIAM J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5 1920.

17 I HEREBY CERTIFY, That I attended deceased from July 25 1920, to Sept. 5 1920.

that I last saw him alive on Sept. 5 1920.

and that death occurred, on the date stated above, at 4:00 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Gastritis 6 wks,

Bronchitis (duration) — yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis?

(Signed) William A. Harris, M. D.

, 19 (Address) 1200 Penn. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mark Auburn	Sept 9 1920
20 UNDERTAKER	ADDRESS
John H Owens	5-38 Druid Hill Ave

046301 HEALTH DEPARTMENT—CITY OF BALTIMORE 046301

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 27 E. Weber Street. ST.: 23 WARD) 19 REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Wilson.(C).

(Residence in Baltimore: No. 27 E. Weber Street. 25 ----- ----. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH.

Do not know. (Month), 1 (Day) (Year)

7-AGE,	If LESS than 1 day,
74 yrs. --- mos. --- ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Whitewasher.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country).

Maryland.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Wilson.(C).(wife).

(Address) 27 E. Weber Street.

15- Filed SEP 7- 1920 191 ROBERT B KRAUTER Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 5th, 1920. (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart and kidneys.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs....mos....ds.

(Signed) Geo. W. Rowland (Coroner.) M. D.

Sept. 6th 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cx	Sept 7, 1920

20-UNDERTAKER	ADDRESS
L. E. Brown's Son	1501 N. Monta St

Imperial. 5-8-20-M.

...—6-9-19—H. P. Co.—1000 Bks.

946302

HEALTH DEPARTMENT—CITY OF BALTIMORE

946302

CERTIFICATE OF DEATH

28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 914 Franklin Road WARD)

2-FULL NAME James M. Seymour

(a) RESIDENCE. No. 914 Franklin Road ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or WIFE of) Margaret Seymour

6 DATE OF BIRTH (month, day, and year) Dec 15-1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plaster

(b) General nature of industry, business, or establishment in which employed (or employer) 057

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER James Seymour

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Susan Rye

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Margaret Seymour

(Address) 914 Franklin Road

15 Date SEP 7 - 1920

ROBERT E. LEUTER

Registrar

Burial Permit Clerk

SEP 7 - 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1920

17

I HEREBY CERTIFY, That I attended deceased from July 6, 1920 to Sept 4, 1920, that I last saw h[illegible] alive on Sept 4, 1920, and that death occurred, on the date stated above, at 7 PM m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (secondary) Pleurisy with effusion

(Duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home of Death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Attending Physician

(Signed) John S. Fretwell M. D.

(Address) 1219 Asplan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine

DATE OF BURIAL Sept 7 1920

20 UNDERTAKER William Cook

ADDRESS 502 E Nor

...c.—8-24-14—M. & T.—2000 Bks.

1046303

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046303

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 Colvin St.; 5 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Davis

Residence in Baltimore: No. 423 Colvin St. (.....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 22 (Day), 1920 (Year)

7-AGE, 2 yrs. 15 mos. ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Arthur Davis

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Levina Wright

13-BIRTHPLACE OF MOTHER (State or Country), Delaware

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Davis

(Address) 423 N. Colvin

15-

Filed SEP 7 - 1920 191.....

ROBERT F. KRAUTER
Burial Permit
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 6 (Day), 1920 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 3, 1920, to Sept 6 1920, that I saw h-- alive on Sept 5 1920, and that death occurred, on the date stated above, at 7.45 a m.

The CAUSE OF DEATH* was as follows:

Primary
Bronchio Pneumonia
(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Exhaustion
(Duration) .....yrs. .....mos. .....ds.

(Signed) Luigi D. DiStefano M. D.

Sept 6, 1920 (Address) 407 N. Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Marys Hanyden | DATE OF BURIAL, Sept 7, 1920

20-UNDERTAKER William Cook | ADDRESS 502 E North Ave

046304

HEALTH DEPARTMENT—CITY OF BALTIMORE

046304

CERTIFICATE OF DEATH.

174

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Maryland Gen. Hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ladd B. Hynes

(Residence in Baltimore: No. 4104 Falls Road St.; yrs. 47 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	white	single

6-DATE OF BIRTH, August 13, 1875
(Month) (Day) (Year)

7-AGE, 45 yrs. 7 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: .031
(a) Trade, profession, or particular kind of work..... Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)..... Crane operator

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, James H. Hynes

11-BIRTHPLACE OF FATHER (State or Country), Howard County

12-MAIDEN NAME OF MOTHER Cornellia Shaw

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Duff

(Address) 4104 Falls Rd.

15- Filed SEP 7 — 1920 191.... ROBERT B KRAUTER Registrar.

Important. Statistics.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 4, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

Result of accidently falling from crane at Sparrows Point (Duration) yrs. mos. 1 ds. Bethlehem Steel Co.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 1 ds.

(Signed) J. E. D. Hennessey M. D. (Coroner)

September 6 1920 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos. 1 ...ds. In the State....yrs....mos....ds. Md. Gen. Hosp.

Where was disease contracted, if not at place of death?.....

Sparrows Point, Bethlehem Steel Co.

Former or usual residence 4104 Falls Road

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cemetery	Sept 7 1920
20-UNDERTAKER	ADDRESS
D S Marshall	3589 Fels Rd

...—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046305

46305

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary 114 REGISTERED NO.

TY OF BALTIMORE: (No. 6 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Amanda Hearer

(a) RESIDENCE. NO. Westminster, Md R.D. # 3. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Edward L. Hearer Living.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Household Work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Sam. Yingling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Edward L. Hearer (Address) Manchester Md

15 Filed SEP 7 - 1920 ROBERT B. REUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to Sept 6, 1920, that I last saw her alive on Sept 6, 1920, and that death occurred, on the date stated above, at 12.55 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis with an acute exacerbation & rupture of Gall Bladder

Cholelithiasis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma peritonii

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 5, 1920

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. D. Noble, M. D

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Manchester Md DATE OF BURIAL Sept 9 1920

20 UNDERTAKER Jacob Mik Sons Manchester Md ADDRESS

ec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

946306

946306

8-091

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 - W-26 St.; 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Elizabeth Peddicord

Residence in Baltimore: No. 425 W-26 St.; ..... yrs., 11 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fe

4-COLOR OR RACE. W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) S.

6-DATE OF BIRTH. Sept. 28, 1919. (Month) (Day) (Year)

7-AGE. ..... yrs. 11 mos. 22 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... ood
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Thomas Peddicord

11-BIRTHPLACE OF FATHER (State or Country). Howard Co Md

12-MAIDEN NAME OF MOTHER Bessie Gordon

13-BIRTHPLACE OF MOTHER (State or Country). Howard Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida E. Peddicord

(Address) 425 - W 26 St

15- SEP 7 - 1920, 191.... ROBERT B. ERAUTER Registrar.
Filed....., Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 6, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 6 1920, to Sept. 6 1920, that I saw her alive on Sept. 4 1920, and that death occurred, on the date stated above, at 40 m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Whooping-cough

..... (Duration) ..... yrs. 1 mos. ..... ds.

(Signed) Roscoe Ehrer M. D.

Sept. 6, 1920 (Address) 2438 Guilford Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Marys H DATE OF BURIAL, Sept. 7, 1920

20-UNDERTAKER A S Marshall ADDRESS 3539 Gaul Rd

ec.—8-24-14—M. & T.—2000 Bks.

46307

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1200 46307

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2737 Presbury ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo W. Sutter

Residence in Baltimore: No. 2737 Presbury St.; 72 yrs., 6 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, March 1, 1848
(Month) (Day) (Year)

7-AGE, 72 yrs. 6 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired 07
(b) General nature of industry, business, or establishment in which employed (or employer): Motorman

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Saml L Suter

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER— Rothrock

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Edna Sutter

(Address) 2737 Presbury St

15-

Filed SEP 7 - 1920, 191.. ROBERT B KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 5, 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1 1916, to Sept 5 1920, that I saw h[im] alive on Sept 5 1920, and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Bright Disease

(Duration) 4 yrs. 4 mos. 5 ds.

CONTRIBUTORY (Secondary) Dropsy

(Duration) yrs. 4 mos. ds.

(Signed) A Melching M. D.

Sept 5 1920 (Address) 303 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Farmer or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cem

DATE OF BURIAL, Sept 8, 1920

20-UNDERTAKER A W McCaulley

ADDRESS 1624 Mt Royal Ave

ec.—8-24-14—M. & T.—2000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46308 — 81 1046308

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH Little - Sisters of the Poor

CITY OF BALTIMORE: (No. Preston & Valley Sts ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Christopher

Residence in Baltimore: No. Little Sisters of the Poor St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow.

6-DATE OF BIRTH, ... September 5th, 1839 ~~1920~~
(Month) (Day) (Year)

7-AGE 92 yrs. 11 mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Boston

PARENTS.

10-NAME OF FATHER, Charles Ballard

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Sarah Ballard

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15- Filed SEP 7- 1920, 191.....
ROBERT E SAUTER
Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... September 5th, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I saw h[illegible] alive on ..... 191...,
and that death occurred, on the date stated above, at 6.30 p.m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Debility of age

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Warner M. D.

Sept 6, 191... (Address) 1138 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 5 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral | DATE OF BURIAL, Sept. 7, 1920

20-UNDERTAKER H. C. Weddefeld | ADDRESS 914 Greene St

...—6-9-19—H. P. Co.—1000 Bks.

946309 HEALTH DEPARTMENT—CITY OF BALTIMORE 946309

CERTIFICATE OF DEATH. 91V

1-PLACE OF DEATH South Balto Gen. Hoo. REGISTERED NO.....

TY OF BALTIMORE: (NO. ..... ST.: 22 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Jaschik

(a) RESIDENCE. NO. 632 W Lee ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mns. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1920.

7 AGE — Years | Months: 4 | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... nov

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Alfred Jaschik

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mildred Lamb.

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md
(State or country)

14 Informant Albert Jaschik
(Address) 632 W. Lee

15 Filed SEP 7 - 1920 19.. BOBERT I KLAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1920, to Sept. 6, 1920, that I last saw her alive on Sept. 6, 1920, and that death occurred, on the date stated above, at 3.40 m.

The CAUSE OF DEATH* was as follows:

Rickets

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Louis C. Dobihal, M. D.

, 19 (Address) S Balto, Gen Hos.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Sept 7 19..
20 UNDERTAKER	ADDRESS
Jos Joerdans Son	1178 Ru

6-9-19—H. P. Co.—1000 Bks.

146310

HEALTH DEPARTMENT—CITY OF BALTIMORE

146310

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. Franklin and Orchard ave 26 WARD)

2-FULL NAME Philipp Minderlein

(a) RESIDENCE. NO. Franklin and Orchard ave 26 WARD. Ralsberg

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Virginia F. Minderlein

6 DATE OF BIRTH (month, day, and year) June 19 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer .040

(b) General nature of industry, business, or establishment in which employed (or employer) Cont. Can Co

(c) Name of employer Continental Can Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Conrad Minderlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Virginia F. Minderlein

(Address) 1701 Ellin and Orchard Ave

15 FILED SEP 7 - 1920 BURIAL PERMIT Registrar

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 19 20.

17 I HEREBY CERTIFY, That I attended deceased from June 19 18. to Sept 5 19 20.

that I last saw h[im] alive on Sept 5 19 20.

and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Fibroid Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. K. Meyer Jr M. D.

9/6, 19 20 (Address) 1638 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept 9 1920

20 UNDERTAKER Lilly & Zeiler

ADDRESS 4038 Wolfe

.—6-9-19—H. P. Co.—1000 Bks.

46311 HEALTH DEPARTMENT—CITY OF BALTIMORE 2046311

CERTIFICATE OF DEATH.

6 109

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Y OF BALTIMORE: (No. St. Joseph Hosp ST.; WARD)

2-FULL NAME Katherine Haas

(a) RESIDENCE. NO. 109 N. Ann ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 64 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	S.

a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

DATE OF BIRTH (month, day, and year) 1856

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John C. Haas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna C. Augustin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Michael S. Haas
(Address) 109 N. Ann St.

15 Filed SEP 7 - 1920 ROBERT F. LEADER
Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1920, to Sept 6, 1920, that I last saw h.e alive on Sept 6, 1920 and that death occurred, on the date stated above, at 3.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Strangulated Femoral Hernia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Sept 5

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank C. Marino, M. D.

9/7/20 (Address) St. Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Sept 8 1920
20 UNDERTAKER Lilly and Zeiler.	ADDRESS 403 S Wolfe St

Rec.—8-24-14—M. & T.—2000 Bks.

46312

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 79 D46312

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. Provident Hospital St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pearl Langhorn

Residence in Baltimore: No. Owens Mills St. 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem.

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, October (Month) (Day) 1882 (Year)

7-AGE. 38 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Curtis Taylor

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Langhorn

(Address) Pleasant Hill, Md.

15- BURIAL PERMIT

Filed SEP 7- 1920, 191 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 5, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Sept 5 1920, that I saw h[illegible] alive on Sept 5 1920, and that death occurred, on the date stated above, at 11 45 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(Duration) yrs. mos. ds.

(Signed) Geo. H. Hall M. D.

Sept 6 191... (Address) 1926 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 28 ds. In the State 5 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL St Lukes Cem, Md DATE OF BURIAL, Sept, 1920.

20-UNDERTAKER Samuel H Kemsley ADDRESS 518 W. Baltimore

—6-9-19—H. P. Co.—1000 Bks.

46313

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 1946313

REGISTERED NO.

1-PLACE OF DEATH

TY OF BALTIMORE: (NO. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Clark.

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE Years 69 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital.

15 SEP 7- 1920 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 3, 1920

17 I HEREBY CERTIFY, That I attended deceased from February 7, 1917 to September 3, 1920, that I last saw him alive on September 2, 1920, and that death occurred, on the date stated above, at 9:45 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteria-sclerosis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopical Exam. M. D.

(Signed) Patterson

9/3/ 1920 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon

DATE OF BURIAL Sept 7 1920

20 UNDERTAKER Daniel Easton

ADDRESS Pa ave 916

6-9-19—H. P. Co.—1000 Bks.

46314 HEALTH DEPARTMENT—CITY OF BALTIMORE 46314

CERTIFICATE OF DEATH. 44

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. New City Hospital ST.: 14 WARD)

2-FULL NAME William Campbell

(a) RESIDENCE. NO. 608 W. Lafayette Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond, Virginia.

PARENTS

10 NAME OF FATHER Traves Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond, Virginia.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) New City Hosp.

15 Filed SEP 7-1920 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5, 1920

17 I HEREBY CERTIFY, That I attended deceased from August 31, 1920, to September 5 1920, that I last saw him alive on September 5, 1920, and that death occurred, on the date stated above, at 10:00 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of face

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Secondary Anemia + hemorrhage (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? not as yet

What test confirmed diagnosis?

(Signed) J. A. Holden, M. D.

9/6/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cem	Sept 7 '20
20 UNDERTAKER David Earley	ADDRESS 916 Co ave

046315 HEALTH DEPARTMENT--CITY OF BALTIMORE 1920 046315

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 34 S High St ST. 3 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Girtrud Schen

(Residence in Baltimore: No. 34 S High St.; 7 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word): Widow

6 DATE OF BIRTH: November (Month), 1 (Day), [illegible] (Year)

7 AGE: 55 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Russia

PARENTS

10 NAME OF FATHER: Abraham Yunkelovitch

11 BIRTHPLACE OF FATHER (State or country): Russia

12 MAIDEN NAME OF MOTHER: Beckie Pass

13 BIRTHPLACE OF MOTHER (State or country): Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Janet Yunkelovitch

(Address) 2714 r North Ave

15 Filed SEP 7 - 1920 191 ROBERT B. KRAUTH Burial Permit REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 7. (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 3rd, 1918, to Sep 6th 1920, that I saw her alive on Sept 6th, 1920, and that death occurred, on the date stated above, at 4 9 a. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) 2 yrs. 6 mos. ds

Contributory (SECONDARY) Dilated heart

(Duration) 1 yrs. mos. ds.

(Signed) M Chideckel M. D.

9/7, 1920 (Address) 2328 Monad. av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. — In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence: 34 S. High St

19 PLACE OF BURIAL OR REMOVAL: Hebrew Rising Sun — DATE OF BURIAL: Sept 7, 1920

20 UNDERTAKER: M. Simon — ADDRESS: 1121 E Baltimore St

#State CAUSE OF DEATH very carefully. See instructions on back of certificate. This is very important.

ec.—8-24-:4—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46316

46316

64

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 651 Bankard Lane St. 35th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Rice

Residence in Baltimore: No. 651 Bankard Lane St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, ..., (Month) (Day) 1875 (Year)

7-AGE, 45 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Junk Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 045

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Amster Rice

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Mary Livett

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Abby Rice

(Address) 651 Bankard Lane

15- FILED SEP 7 1920 191.... ROBERT A. LEE STATE Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 5, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1 1920, to Sept 5 1920, that I saw him alive on Sept. 5 1920, and that death occurred, on the date stated above, at 12 M. p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis unknown

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John A. Kladovsky M. D.

Sept. 6, 1920. (Address) 638 Columbia Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 651 Bankard Lane

19-PLACE OF BURIAL OR REMOVAL, Lancaster Co Va

DATE OF BURIAL, Sept 9, 1920

20-UNDERTAKER John W Henderson

ADDRESS 1502 E Monument St

McKim Beck Wharf

D 46317

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46317

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1802 Druid Hill Ave ST.: 14 WARD)

REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis F. Perry

(Residence in Baltimore: No. 1802 Druid Hill Ave St.; 26 yrs., 5 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	Colored	married

6-DATE OF BIRTH, March 17, 1894 (Month) (Day) (Year)

7-AGE, 26 yrs. 5 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Post Office Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): U. S.

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Daniel Perry

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Melvia Buchanan

(Address) 1802 Druid Hill Ave.

15-

Filed SEP 7 - 1920 191.... ROBERT F. LEACH Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 5, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(Duration) ....yrs. 4 mos. ....ds.

(Signed) J. D. Hennessy (Coroner.) M. D.

Sept. 7, 1920 (Address) J. D. Hennessy

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem'y	Sept. 6, 1920
20-UNDERTAKER George H. Holland	ADDRESS 1634 Harford Ave

important. See instructions on back

...-6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46318

CERTIFICATE OF DEATH.

D46318

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1320 N. Stricker ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Kelly

(a) RESIDENCE. NO. 1320 N. Stricker WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE col

5 Single, Married, Widowed, or Divorced (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Kelly

6 DATE OF BIRTH (month, day, and year) Mar 4 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	6	1 day	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman on Boat

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Susie Denton (Address) 1320 N. Stricker

15 Filed SEP 7 - 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1920, to Sept 5, 1920, that I last saw h live on Sept 4, 1920, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. (Coroner) mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Regular

(Signed) F. C. Linthicum M.D.

(Address) 1320 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violence state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int Auburn Cmty	Sept 7 1920

20 UNDERTAKER George H. Holland ADDRESS 1631 Druid Hill Ave

ROBERT E. LEMMON Burial Permit Clerk

D 46319 HEALTH DEPARTMENT—CITY OF BALTIMORE D 46319

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 28

CITY OF BALTIMORE (No. Bayview Hospital ST. WARD) . (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Della Lockard

(Residence in Baltimore: No. 621 W Mulberry St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, Colored | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June 10, 1896 (Month) (Day) (Year)

7-AGE, 24 yrs. 2 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Servant
(b) General nature of industry, business, or establishment in which employed (or employer) 07

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, Rhodes

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Sarah

(Address) 621 W Mulberry

15-

Filed SEP 7 - 1920 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 3, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry Lyn Price M.D. (Coroner.)

Sept 6, 1920 (Address) 1100 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Auburn Cem. | DATE OF BURIAL, Sept 8. 1920

20-UNDERTAKER George H. Holland | ADDRESS 1631 Pennsylvania Ave

ec.—6-9-19—H. P. Co.—1000 Bks.

846320

HEALTH DEPARTMENT—CITY OF BALTIMORE

846320

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. New City Hospital St. 26 Ward) 40

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua J.S. Brown

(a) RESIDENCE. No. Unknown St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
abt	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Stella Brown
(Address) 2606 N. Calvert St

15 Filed SEP 7 - 1920 ROBERT P. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6, 1920

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1920, to Sept. 6, 1920, that I last saw h.. im alive on September 6, 1920, and that death occurred, on the date stated above, at 3:50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray exam

(Signed) W B Newman, M. D.

9/7/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodensburg - M.P. Balto Co.	Sept 8 - 1920
20 UNDERTAKER	ADDRESS
William Cook	502 S. Vatt

...ec.—8-24-14—M. & T.—2000 Bks.

46321 HEALTH DEPARTMENT—CITY OF BALTIMORE 15 12 46321

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Womans Hospital

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Lafayette + John ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Means

Residence in Baltimore: No. 2246 Guilford Ave St.; 0 yrs., 0 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept. 4, 1920 (Month) (Day) (Year)

7-AGE, 0 yrs. 0 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Womans Hospital, Balto., md.

PARENTS.

10-NAME OF FATHER, Howard Means

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Nettie Leonard

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes Means

(Address) 2246 Guilford Ave.

15- ROBERT J. KRAUTER

Filed SEP 7 - 1920 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 6, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 4 1920, to Sept 6 1920, that I saw him alive on Sept 6 1920 and that death occurred, on the date stated above, at 6.55 A m.

The CAUSE OF DEATH* was as follows:

premature in fant

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs....mos....ds.

(Signed) Helene Dautsch M. D.

....., 191... (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Hanford Road | DATE OF BURIAL, Sept. 8, 191..

20-UNDERTAKER William Cook | ADDRESS 5032 North Ave

...—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

846322

CERTIFICATE OF DEATH.

120 D 46322

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 St Peter St. WARD 21)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Trott

(a) RESIDENCE. No. 808 St Peter St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J Trott

6 DATE OF BIRTH (month, day, and year) aug 31 1851

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 209

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) annapolis - md.

PARENTS

10 NAME OF FATHER Benjamin Trott

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Thomas Mackabee 908 S. Carey St.

15 Filed SEP 7 — 1920 ROBERT P. LAMASE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/7/ 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Sept 7 1920.

that I last saw him alive on Sept 7 1920.

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Obstructing Bladder

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen A Dorsey M. D.

, 19 (Address) 120 W Columbia St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Annapolis - A.A.Co. Md	Sept 10 - 1920
20 UNDERTAKER William Cook	ADDRESS 602 E. North Ave

...—6-9-19—H. P. Co.—1000 Bks.

Gertrude Cook.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46323

CERTIFICATE OF DEATH.

113 D 46323

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

...TY OF BALTIMORE: (No.) 1361 Andre ST. 24th WARD)

2-FULL NAME Cook, Gertrude

(a) RESIDENCE. NO. 1361 Andre ST., 24th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles J. Cook.

7 DATE OF BIRTH (month, day, and year): Aug 10 - 1872

AGE: Years 48 | Months — | Days 26 | If LESS than 1 day, ... hrs. or ... min. X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): — 037

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Camden, N.J

PARENTS

10 NAME OF FATHER: Wm. Van Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Camden N.J.

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant: Charles Cook (Address) 1361 Andre

15 Filed SEP 7 - 1920 19... Registrar

ROBERT F. XIL... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9 - 5 - 1920

17 I HEREBY CERTIFY, That I attended deceased from 8 - 1 -, 1920, to 9 - 5 -, 1920.

that I last saw her alive on 9 - 4 -, 1920

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver.

probably (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Palpation, urinalysis.

(Signed) D. Pirosh, M. D.

, 19 (Address) 2202 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill

DATE OF BURIAL: Sept 8 - 1920

20 UNDERTAKER: William Cook

ADDRESS: 502 E North Ave

...—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

046324

CERTIFICATE OF DEATH.

81 D 46324

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 714 N. Lakewood St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. B. Graham

(a) RESIDENCE. No. 714 N. Lakewood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

6a If married, widowed, or divorced (or) WIFE of: Benj. Graham

6 DATE OF BIRTH (month, day, and year): Aug 31/54

7 AGE: Years 86 | Months - | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: at Home

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Jas. Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Geo W. Shipley

(Address) 714 N. Lakewood

SEP 7- 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to Sept 4, 1920, that I last saw her alive on Sept 4, 1920, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Geo Clinton Stadler M. D.

(Address) 1436 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet — DATE OF BURIAL: Sept 8 1920

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans

6-9-19—H. P. Co.—1000 Blks.

46325

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

26 VS 46325

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1160 Cleveland St. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kathryn Burnham.

(a) RESIDENCE. NO. 1160 Cleveland St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female.	white.	married.

a If married, widowed, or divorced HUSBAND of (or) WIFE of Gilbert Burnham.

6 DATE OF BIRTH (month, day, and year) Nov 22, 1889.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	9	14	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Operator,

(b) General nature of industry, business, or establishment in which employed (or employer) C,C,P Tel, Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brooklyn, N.Y.

PARENTS

10 NAME OF FATHER Thos M. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York.

12 MAIDEN NAME OF MOTHER Mary Regan.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York.

14 Informant Mr Thos M. Clark.
(Address) 1160 Cleveland St.

15 Filed SEP 7 — 1920 ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1920, to Sept. 5, 1920, that I last saw her alive on Sept. 5, 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pellagra ?

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) E Bronchitis (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No

(Signed) Noland E Blake M. D.

, 19 (Address) 1014 N. Lafayette.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery.

DATE OF BURIAL: Sept.8 1920

20 UNDERTAKER: J.J. COWAN & SON.

ADDRESS: 901 Hollins.

...—6-9-19—H. P. Co.—1000 Bks.

46326

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D 46326

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 S. Dallas ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Smith

(a) RESIDENCE. No. 117 S. Dallas ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Smith

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fabarre 040

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER Albert Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. D. C.

12 MAIDEN NAME OF MOTHER Mary Milford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash. D. C.

14 Informant Arthur Smith
(Address) 117 S. Dallas St

15 Filed SEP 7 - 1920 [illegible] Registrar

Burial Permit Oiss[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1920, to Sept 6, 1920, that I last saw him alive on Sept 6, 1920, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed Diagnosis?

(Signed) Robert J Grimm, M. D.

9-6, 1920 (Address) 120½ Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Grove	9/9/20
20 UNDERTAKER	ADDRESS
Thos F White	1132 Wolfe

...c.—8-24-14—M. & T.—2000 Blks.

46327 HEALTH DEPARTMENT—CITY OF BALTIMORE 46327

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 3116 Dillon St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Golden L. Cannon

Residence in Baltimore: No. 3116 Dillon St St.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Jan 13, 1898.
(Month) (Day) (Year)

7-AGE, 22 yrs. 8 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Conductor
(b) General nature of industry, business, or establishment in which employed (or employer) 078

9-BIRTHPLACE, (State or Country), Dorchester Co Md

PARENTS.

10-NAME OF FATHER, Saml J. Cannon

11-BIRTHPLACE OF FATHER (State or Country), Dorchester Co Md

12-MAIDEN NAME OF MOTHER Susan J Simmons

13-BIRTHPLACE OF MOTHER (State or Country) Dorchester Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Saml J. Cannon

(Address) Golden Hill, Dorchester Co. Md.

15- Filed SEP 7- 1920 191 ROBERT B KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep 5, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from at home Sep 1920, to Sep 5 1920, that I saw h-m alive on Sep 5 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Fever, enteritis

Drug addict at State Sanatorium apt (

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. J. Kaufmann M. D.

Sept 6, 1920. (Address) 2035 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cemetery

DATE OF BURIAL, Sept 8, 1920

20-UNDERTAKER Zickler & Zickler

ADDRESS 1739 E. Eager St.

6-9-19—H. P. Co.—1000 Bks.

46328 HEALTH DEPARTMENT—CITY OF BALTIMORE 46328

CERTIFICATE OF DEATH

1-PLACE OF DEATH Bayview Hospital 11 REGISTERED NO. 37

CITY OF BALTIMORE (NO. , ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Pedroja

(a) RESIDENCE. NO. Unknown ST., 851 Hamilton Terrace WARD.

(Usual place of abode) Unknown (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1879.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto & Ohio R.R. Co

9 BIRTHPLACE (city or town) (State or country) Switzerland Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant Bayview Hospital (Address) Balto. Md.

15 Filed SEP 7 - 1920 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15, 1920. to Sept 6, 1920. that I last saw him alive on Sept 5 1920 and that death occurred, on the date stated above, at 8.20 a.m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Insane)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathological test

(Signed) N. Feldonich M. D.

9/6/1920 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ~~Loudon Park~~ DATE OF BURIAL 9/8 1920

20 UNDERTAKER Jack Lewis ADDRESS 1411 E. Balt

Spec.—8-24-14—M. & T.—2000 Bks.

46329 HEALTH DEPARTMENT—CITY OF BALTIMORE D 46329

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 Light St. St.; 23 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Henning.

(Residence in Baltimore: No. 1616 Light St. St.: 64 yrs., 7 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, January 16, 1856 (Month) (Day) (Year)

7-AGE, 64 yrs. 7 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Foreman 078
(b) General nature of industry, business, or establishment in which employed (or employer)..... United Railway

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Henning.

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Henning

(Address) 1616 Light St.

15- Robert P. Harrison,

Filed ....., 191.... Burial Permit Clerk Registrar.

SEP 7- 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 5 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 24 1920, to 9.5 1920, that I saw h[illegible] alive on 9.5 1920, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma. Chron.

(Duration) 5 yrs. mos. ds.

(Signed) D Turnbaugh M. D.

9.6, 1920 (Address) 1028 Fawn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Peters Cem DATE OF BURIAL, Sep. 8, 1920

20-UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light St.

...—6-9-19—H. P. Co.—1000 Bks.

46330 HEALTH DEPARTMENT—CITY OF BALTIMORE D46330

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH REGISTERED NO.....

TY OF BALTIMORE: (No. Mercy Hospital ST. 77 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nelson Walker.

(a) RESIDENCE. No. 819 Bevan ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer,

(b) General nature of industry, business, or establishment in which employed (or employer): O40

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: John Walker.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Ethelyn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address)

15 Filed SEP 7 - 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, dny, and year): Aug 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1920, to Aug 31, 1920, that I last saw him alive on Aug 31, 1920, and that death occurred, on the date stated above, at 6 40 p.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia.

CONTRIBUTORY (Secondary) (duration) yrs. Pulmonary Embolism, mos. 1 ds.

(duration) yrs. mos. hrs. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What lest confirmed diagnosis? Clinical

(Signed) Alex Sivers, M. D

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mercy Hospital

DATE OF BURIAL: SEP 7 - 1920

20 UNDERTAKER: Commissioner Health,

ADDRESS

Dr. WM. R. WOODALL

...—6-9-19—H. P. Co.—1000 Bks.

46331 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46331

CERTIFICATE OF DEATH. 1 × 109

1-PLACE OF DEATH REGISTERED NO.....

TY OF BALTIMORE: (No. Mercy Hospital ST.: 1 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Kelbough

(a) RESIDENCE. No. Parkton Md ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 64

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Parkton Md

PARENTS

10 NAME OF FATHER Henry Kelbaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) York County Pa.

12 MAIDEN NAME OF MOTHER Julia Lovell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address)

15 Filed SEP 7 - 1920 19 Registrar Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1920

17 I HEREBY CERTIFY, That I attended deceased from noon, 9/3 , 1920, to 9/3/20 5:30 P.M. that I last saw him alive on 9/3/20 at 4:30 P.M. 1920, and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

General peritonitis - Over

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? ✓

Did an operation precede death? Yes Date of 9/3/20

Was there an autopsy? No

What test confirmed diagnosis? Presence of Pus in Abdomen

(Signed) D. C. Ridgely, M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND.	SEP 7 - 1920

20 UNDERTAKER Commissioner Health, per. Wm. E. WOODALL ADDRESS

Dec.—8-24-14—M. & T.—2000 Bks.

46332

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 46332
42

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 133 W. Camden ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Concetta Naso

Residence in Baltimore: No. 133 W. Camden St.; 14 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH. Sep. 7, (Month) (Day) 1846, (Year)

7-AGE. 74 yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country). Italy

PARENTS.

10-NAME OF FATHER. Giuseppe Naso

11-BIRTHPLACE OF FATHER (State or Country). Italy

12-MAIDEN NAME OF MOTHER Rosaria Ranzma

13-BIRTHPLACE OF MOTHER (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Scandura

(Address) 133 W. Camden St.

15- Burial Permit Clerk.

Sept. 9 1920

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep. 7, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1920, to Sep. 7 1920, that I saw her alive on Aug 15, 1920, and that death occurred, on the date stated above, at 12.10 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Eugene L. Pessano M. D.

Sept. 9, 1920 (Address) 2314 E. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt. Olivet

DATE OF BURIAL. Sept. 9, 1920

20-UNDERTAKER Julia Kane

ADDRESS 1318 E. Eighth St

Robert P. Harrison

0.46333 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.46333

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 6th, St. & 2nd, Ave. Fairfield ST.: 25 WARD) 19

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julius R. Ruffin. (C).

(Residence in Baltimore: No. 6th, St. & 2nd, Ave. Fairfield. St.: 10 yrs., ---- mos. ---- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH,

Do not know. (Month), 1 (Day) (Year)

7-AGE,	If LESS than 1 day,
43 yrs. ---- mos. ---- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer in Guano
(b) General nature of industry, business, or establishment in which employed (or employer): Guano Plant.

9-BIRTHPLACE, (State or Country).

North Carolina.

PARENTS.

10-NAME OF FATHER. Thomas Ruffin. (C).

11-BIRTHPLACE OF FATHER (State or Country). North Carolina.

12-MAIDEN NAME OF MOTHER Lucy ----. (C).

13-BIRTHPLACE OF MOTHER (State or Country). North Carolina.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Bates. (C). (brother-in-law).

(Address) 6th, St. & 2nd Ave. Fairfield.

15-

SEP 7 1920 Filed....., 191.....

Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 5th, 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

....Valvular disease of the Heart.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

Sept. 7th, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn et	Sept 8, 1920

20-UNDERTAKER	ADDRESS
L. E. Brown's Son	108 N. Monroe

...—6-9-19—H. P. Co.—1000 Bks.

46334 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46334

CERTIFICATE OF DEATH. X 104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 Tendenhall ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Screen

(a) RESIDENCE. NO. 924 Tendenhall ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown 5 mos

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	—	5 mos	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER Wm Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Susie Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant (Address) Jamie Woodland 924 Tendenhall St

15 Filed SEP 7 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/7/ 1920

17 I HEREBY CERTIFY, That I attended, deceased from 9/1/ 1920, to 9/7/ 1920, that I last saw h[illegible] alive on 9/7/ 1920, and that death occurred, on the date stated above, at 8:10 a. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) 1 mos. ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Gunbroley, M. D

9/7/ 1920 (Address) 908 Dolphin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lauden Park Cemetery	Sept 8 1920
20 UNDERTAKER	ADDRESS
John H. Faudrin	142 N. Hill St

D.46335 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46335

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE (No. 24 E. Montgomery St. St.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Hutchinson.

(Residence in Baltimore: No. 24 E. Montgomery St. St.; 56 yrs., ---- mos. ---- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Married.

6-DATE OF BIRTH, Do not know. (Month), 1 (Day), ... (Year)

7-AGE,	If LESS than 1 day,
56 yrs. ---- mos. ---- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Alfred Mullen.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Martha Lee.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert E. Hutchinson. (husband)

(Address) 24 E. Montgomery St.

15- Robert P. Harrison,

Filed SEP 7 1920, 191..... Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 5th, 1920. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Sept. 7th, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	Sept 8, 1920
20-UNDERTAKER John F. Denny	ADDRESS 716 Light St

D.46336 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46336

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE (No. 304 S. 4th, St. Brooklyn. ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. George N. Meyers.

(Residence in Baltimore: No. 304 S. 4th, St. Brooklyn. St.: 7 -- 5 -- 21. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, March 16th, 1913., 1.....
(Month) (Day) (Year)

7-AGE, 7 yrs. 5 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.:

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph G. Meyers.

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER Viola Noble.

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola Meyers, (mother).

(Address) 304 S. 4th, St. Brooklyn.

15-

Filed SEP 7 1920, 191.....

Robert P. Harrison,
Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 6th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....(Microcepalia).....
.....Broncho-pneumoria.....
..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....
..... (Duration).....yrs.....mos.....ds.

(Signed) Geo. M. Reinhardt M. D.
(Coroner.)

Sept. 7th, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.....mos.....ds. In the State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet	9/8, 1920
20-UNDERTAKER	ADDRESS
John J. Daley Sons	318 Light

046337 HEALTH DEPARTMENT—CITY OF BALTIMORE 046337

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Franklin Square Hospital ST.: 19 WARD) 75-00

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis M. Lemmon

(Residence in Baltimore: No. 1345 Ramsay St St.: yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Sing'l

6-DATE OF BIRTH, Oct (Month) 18 (Day), 1914 (Year)

7-AGE,	If LESS than 1 day,
5 yrs. 10 mos. 20 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, James E Lemmon

11-BIRTHPLACE OF FATHER (State or Country). Balto City

12-MAIDEN NAME OF MOTHER Theresa Farrell

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Farrell

(Address) 1345 Ramsay St

15- Filed SEP 8 - 1920, 191. ROBERT F KRAUTER Registrar. Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 6 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Base of Skull
Lower Jaw
Auto accident

(Duration) ....yrs. ....mos. 1/2 hr.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) James M Reuben M. D. (Coroner.)

Sept 7 1920 (Address) 1005 Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Franklin Sq Hosp In the of death....yrs....mos. 5 Ms state....yrs....mos....ds.

Where was disease contracted, if not at place of death? Prob 1345 Ramsay St

Former or usual residence 1345 Ramsay St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross Cemetery	Sept 8, 1920

20-UNDERTAKER	ADDRESS
James D'Agnon & Son	1000 S Paca St

pec.—8-24-14—M. & T.—2000 Bks.

046338

HEALTH DEPARTMENT—CITY OF BALTIMORE

046338

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2111 W. Baltimore St.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Watson

(Residence in Baltimore: No. 2111 W. Baltimore St.: 47 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M | 4-COLOR OR RACE, W. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct (Month) 10 (Day), 1872 (Year)

7-AGE, 47 yrs. 10 mos. 24 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Painter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm W. Watson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Annabel Hanks

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Grace Watson

(Address) 2111 W Balt St

15-

Filed SEP 8 - 1920, 191.... ROBERT B KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 5 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1917, to Sept 5 1920, that I saw h.. alive on Sept 3 1920, and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Auto Intoxication

(Duration) yrs. 7 mos. ds.

(Signed) Edward O'Conlan M. D.

9/8/20, 191... (Address) 24 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. | In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Fremont Cem | DATE OF BURIAL, 9/8/20, 191...

20-UNDERTAKER Geo A Farley | ADDRESS Fulton & Fayette

Important

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046339

1046339

170

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 N Stricker St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Courtland Hall

(Residence in Baltimore: No. 1013 N. Stricker St. St.; Life yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, January 1, 1873
(Month) (Day) (Year)

7-AGE. 47 yrs. 8 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Civil Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Insurance

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Thos Hall

11-BIRTHPLACE OF FATHER (State or Country), Conn

12-MAIDEN NAME OF MOTHER Sarah Rose

13-BIRTHPLACE OF MOTHER (State or Country), R. I.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie L. Hall

(Address) 1013 Stricker

15- SEP 8 - 1920 ROBERT F. BAETTER
Filed....., 191.. Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 6, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Sept 4 1920, to Sept 6 1920

that I saw h... alive on Sept 6 1920

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

Chronic Parenchymatous Nephritis (Duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frederick Dillon M. D.

Sept 6 1920 (Address) 1401 E. 20th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Sept 9, 1920.

20-UNDERTAKER Mr Cook — ADDRESS 502 E North Ave

...c.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~46340~~ 120 2046340

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

...ITY OF BALTIMORE: (NO. 777 W. Cross ST.: 21 WARD)

2-FULL NAME Anna B. Rumney

(a) RESIDENCE. NO. 777 W. Cross ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H Rumney

6 DATE OF BIRTH (month, day, and year) Sept 8, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	66	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Schubat

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Nol Ruborn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John H. Rumney

(Address) 777 W Cross St

15 Filed SEP 8 — 1920 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1920

17 I HEREBY CERTIFY, That I attended deceased from June, 1920, to Sept. 6th, 1920, that I last saw h...r alive on Sept 2nd, 1920, and that death occurred, on the date stated above, at 10 A...m.

The CAUSE OF DEATH* was as follows:

Chron[illegible] Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Grunthen, M. D.

9/6/20 (Address) 51 Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept 8 1920
20 UNDERTAKER	ADDRESS
H Kenderdine Son	1710 Fleet St

ec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46341 — 1046341 — 104

REGISTERED NO.....

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 718 S. Ouley ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leroy H Poke

(a) RESIDENCE. NO. 718 S. Ouley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 24 20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles A Poke

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Bertha Ruppert

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mrs. Charles A. Poke
(Address) 718 S. Ouley St.

15 Filed SEP 8 - 1920 ROBERT E LEATHER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Sept 7 1920,
that I last saw h— alive on Sept 7 1920.
and that death occurred, on the date stated above, at —m.
The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) J Weston, M. D.

1920 (Address) 10 O Ouley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Oak Lawn Cem	Sept. 8 1920

20 UNDERTAKER ADDRESS

Geo J. Kerr 156 N. Luzerne Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

946342 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓946342

CERTIFICATE OF DEATH. 108

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Provident Hospital St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Bazinham

(Residence in Baltimore: No. 1923 Division St.; 5 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, ... (Month); 1 (Day); ..... (Year)

7-AGE, 27 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 031

9-BIRTHPLACE, (State or Country), Orange N.J.

PARENTS.

10-NAME OF FATHER, Irwin Crowell

11-BIRTHPLACE OF FATHER (State or Country), North Caline

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), North Caline

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H. Dennis

(Address) 1303 Prestman St.

15- ROBERT B KRAUTER Registrar.

Filed SEP 8 1920 191 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 6, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5 1920, to Sept 6 1920, that I saw h er alive on Sept 6 1920, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Peritonitis

from history (Duration) yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Appendicitis

from history (Duration) yrs. ..... mos. 14 ds.

(Signed) S. R. Hughes M. D.

Sept 7 1920 (Address) 1413 S. Hill St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 1923 Division St

Former or usual residence "

19-PLACE OF BURIAL OR REMOVAL, Orange N.J. DATE OF BURIAL, SEP 8 1920

20-UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST.

Spec.—8-24-14—M. & T.—2000 Bks.

46343 HEALTH DEPARTMENT—CITY OF BALTIMORE D 46343

CERTIFICATE OF DEATH.

53

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 N. Belnord Ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Bernard

(Residence in Baltimore: No. 718 N Belnord Ave St.; ....yrs. ....mos. ....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH, March (Month) 18 (Day) 1918 (Year)

7-AGE, 2 yrs. 5 mos. 19 da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Infant ads.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Frank Bernard

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Mary Kanasky

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Bernard

(Address) 718 N Belnord Ave

15-

Filed SEP 8 1920 191... OBERY R KRAUTER

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 6 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 23 1920, to Sept 6 1920, that I saw h— alive on Sept 6 1920, and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Mylogenous Leukaemia

(Duration) ....yrs. ....mos. 21 da.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) ....yrs. ....mos. ....da.

(Signed) Wesley R Kennedy M. D.

9/7/20, 191... (Address) 50 E Mt Vernon Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL. Sept 8, 1920

20-UNDERTAKER Frank Enoch Son — ADDRESS 1916 Eastern Ave

...c.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

946344 946344 946344

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 418 W Camden ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antonio Britti

(Residence in Baltimore: No. 418 W. Camden St St.; ....yrs., 11 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept 14, 1919
(Month) (Day) (Year)

7-AGE, ...yrs. 8 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Giuseppe Britti

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rosina Fazio

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Giuseppe Britti

(Address) 418 W. Camden St

15- ROBERT ... Registrar.

Filed, SEP 8 - 1920, 191.... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 7, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1920, to Sept 7 1920, that I saw h... alive on Sept 7 1920, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

.....

Dysentery

..... (Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Luigi D. di Stefano M. D.

Sept 7, 1920 (Address) 407 N. Exeter St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem

DATE OF BURIAL, Sept 8, 1920

20-UNDERTAKER John J Cowen & Son

ADDRESS 901 Hollins St

c.—6-9-19—H. P. Co.—1000 Bks.

1046345

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046345

CERTIFICATE OF DEATH.

137

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1327 Wirt ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine R. Gately

(a) RESIDENCE. NO. 1327 Wirt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Gately

6 DATE OF BIRTH (month, day, and year) May 7-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	35	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Riordon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eliz Kelleher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John J. Gately

(Address) 1327 Wirt St

15 Filed SEP 8 - 1920 ROBERT F. HAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 28th 1920 to Sept 7th 1920, that I last saw h alive on Sept 7th 1920, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Dr Burgoth Cured

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jno Feeney M. D.

Sept 7 1920 (Address) 1501 Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Sept 11 1920
20 UNDERTAKER	ADDRESS
F. A. Fraver + Son	1, 37 Hanover

1046346 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046346

CERTIFICATE OF DEATH. X 170 REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. University Hospital ST.: 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Chas Edmund Dyer (Died at Hospital)
(Residence in Baltimore: No. Md Nanny School near Lowen St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single
6-DATE OF BIRTH, Aug 10, 1901 (Month) (Day) (Year)
7-AGE, 19 yrs. mos. ds. If LESS than 1 day, ...hrs. or.....min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work School (b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE, (State or Country), Md.

PARENTS.
10-NAME OF FATHER, Emory Dyer
11-BIRTHPLACE OF FATHER (State or Country), Md.
12-MAIDEN NAME OF MOTHER Grace Browning
13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A Stepson
(Address) Sykesville Md

15- Filed SEP 8-1920, 191..... ROBERT B KRAUTER Registrar. Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 7, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy or~~ Inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Bullet Wound by Bgmr
Fired accidental while at
Target Practice (Duration) yrs. mos. ds.
CONTRIBUTORY accidental a few hours
(Secondary) (Duration) yrs. mos. ds.
(Signed) W R Forrest M. D.
(Coroner.)
9-8, 1920 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Sykesville Md — DATE OF BURIAL, Sept 11, 1920
20-UNDERTAKER Fred A Heer — ADDRESS Sykesville

046347 HEALTH DEPARTMENT—CITY OF BALTIMORE 046347

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 819 Mc Donough St.; 7 WARD) REGISTERED No. C 79

2-FULL NAME James H. Dixon

(Residence in Baltimore: No. 819 Mc Donough. St.; yrs. 11 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, C

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (*Write* the word.) Married

6-DATE OF BIRTH, Not known, (Month) (Day) 187[illegible] (Year)

7-AGE, 46 yrs. mos. ds. If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Balto Maryland

PARENTS.

10-NAME OF FATHER, Henry Dixon

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER C. Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Smith

(Address) 819 Mc Donough St

15- SEP 8 1920 ROBERT B KRAUTER Registrar.
Filed ..... 191... Burial Permit Issued

important. See instructions on back.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 7, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonal Regurgitation

(Duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. mos. 1 ds.

(Signed) G. L. Blades, M. D. (Coroner.)

9/7/20 (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel cmtry — DATE OF BURIAL, Sept 9 1920

20-UNDERTAKER Mrs Robt A Elliott — ADDRESS 1725 E Baltimore

1046348 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046348

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Eutaw & Lexington Sts ST.: 17 79 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas H Johnson

(Residence in Baltimore: No. 633 George St. St.: Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, ... Dont Know (Month) (Day), 1855 (Year)

7-AGE, 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Woman
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country): Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country): Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm R A Elliott

(Address) 1723 Ashland Ave

15- Filed SEP 8 - 1920, 191 ROBERT F KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept (Month) 6 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

..... (Duration) ..... yrs. a few days ds.

CONTRIBUTORY (Secondary) Dont Know

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Gorsuch M. D. (Coroner.)

9-7- 1920 (Address) 117 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Sept 10, 1920

20-UNDERTAKER Wm Robert A Elliott — ADDRESS 1720 Ashland Ave

Important. Be sure to answer every question.

...6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~0~~46349 ~~0~~46349

REGISTERED NO. 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3905 (St.) Phila. Ave (Ward) 26

2-FULL NAME Margaret N. Smith

(a) RESIDENCE. No. 3905 St. Phila Ave Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

6 If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of

7 DATE OF BIRTH (month, day, and year) June 5/19

AGE: Years 1 | Months 3 | Days 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry C. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta Boultmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Henry C. Smith
(Address) 3905 E Phila ave

15 Filed SEP 8 - 1920 19 ROBERT E LEAUTEN Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1920

17 I HEREBY CERTIFY, That I attended deceased from 9/6 19 20, to 9/7 19 20, that I last saw h[illegible] alive on 9/7 19 20, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

acute Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) acute dil. of heart.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benson N. Grow, M. D.

19 (Address) 1706 W. north ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: M A Carmel — DATE OF BURIAL: Sept 9 1920

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans

6-9-19—H. P. Co.—1000 Bks.

246350

HEALTH DEPARTMENT—CITY OF BALTIMORE

1 20.46350

105

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child's Hospital ST. 18 WARD)

2-FULL NAME Harry Archer

(a) RESIDENCE. NO. Nursery & Child's Hospital ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-14-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Oscar Archer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Frieda Wunda

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Robert P. Harrison JOHNS
(Address)

Filed SEP 8- 1920 Burial Permit Clerk
Registrar

1718

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5, 1920

17 I HEREBY CERTIFY, That I attended deceased from August 14, 1920, to Sept 5, 1920, that I last saw him alive on Sept 5, 1920, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Infections Diarrhoea,
(Organism unknown)

(duration) yrs. mos. 21 ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Examination of Intestines

(Signed) J. J. Deuglerow M. D.

19 (Address) 2002 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS SEP 8 - 1920

Commissioner Health.

WM. E. WOODALL

SEP

D.46351 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46351

CERTIFICATE OF DEATH.

37

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St. 13 WARD)

2-FULL NAME George Irving

(Residence in Baltimore: No. 100 Front St ? St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) S

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, about 5-4 yrs' ....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Unknown

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address).....

15- Filed Sept 8, 1920, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk
17189

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 2, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy?)

Duration 3 days yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

Duration 3 days yrs. mos. ds.

(Signed) Wm. A. Reed M. D. (Coroner.)

Sept 8, 1920 (Address) 1627 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 days yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ..., 19....

20-UNDERTAKER Commissioner Health, ADDRESS SEP 8 - 1920

Per. WM. R. WOODALL.

important. See instructions

UNIVERSITY OF MARYLAND.

D.46352 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46352

CERTIFICATE OF DEATH. 184

1-PLACE OF DEATH Found between Cary & Calhoun REGISTERED NO. C

CITY OF BALTIMORE (No. on Fairmount Ave STH 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME unknown

(Residence in Baltimore: No. unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, unknown, 1 (Month) (Day) (Year)

7-AGE, New Born yrs. mos. ds. If LESS than 1 day, 1/ hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None (obv)
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balt City

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country) unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- Filed SEP 8 1920, 191 Robert P. Harrison, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 4, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Own death on the day stated above.

The CAUSE OF DEATH* was as follows: Cause unknown Probably destroyed by the party who left on the Street (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) James McFaulon M. D. (Coroner.)

Sept 4 1920 (Address) 700 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	, 19
20-UNDERTAKER Dept. of Health. Per. Wm. T. WOODALL.	ADDRESS SEP 1920

Probably homicide. Dr. Fenton could not tell very much

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first**, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to same.

—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46353

CERTIFICATE OF DEATH.

46353

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3901 (St.) Bell Ave (Ward) 15 X 28

REGISTERED NO. D46353

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna C. Fogle

(a) RESIDENCE: No. 3901 St. Bell Ave Ward. Phila. Pa.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? 50 yrs. 5 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Camden New Jersey

PARENTS

10 NAME OF FATHER Patrick Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Leary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Frank King
(Address) 3901 Bell Ave

15 Filed . 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 19 20

17 I HEREBY CERTIFY, That I attended deceased from July 20 . 1920 . to Sept 8 . 1920 . that I last saw her alive on Sept 6 . 1920 . and that death occurred, on the date stated above, at 9 a.m. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Laryngis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Philadelphia

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & microscopical

(Signed) James M Boulden, M. D.

9/8, 19 (Address) 7 W Chelten Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chester - Pa.	Sept 8 1920

20 UNDERTAKER Henry Hoeck Son

ADDRESS 130 E Eager

46354 HEALTH DEPARTMENT---CITY OF BALTIMORE D.46354

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 N. Fulton Ave ST. 19 WARD) 79

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Thomas Daly

(Residence in Baltimore: No. 123 N. Fulton Ave. St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male.

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Feb 25 (Month) Balto Md (Day), 1854 (Year)

7-AGE: 66 yrs. 6 mos. 10 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Justice of peace
(b) General nature of industry, business, or establishment in which employed (or employer): Magistrial at Large 086

9-BIRTHPLACE (State or country): Balto. Md.

PARENTS

10-NAME OF FATHER: Henry T. Daly.

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: not known

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hattie B. Daly

(Address) 123 N. Fulton Ave

15- Filed SEP 8 1920 191 Robert P. Harrison, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept (Month) 7 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 7, 1920, to Sept 7 1920, that I saw h.im alive on Sept 7 1920, and that death occurred, on the date stated above, at 6.50 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Lesion of Heart about 2 yrs mos ds. (Duration)

Contributory (SECONDARY) Arteriosclerosis about 6 yrs mos ds. (Duration)

(Signed) Walter E. Kirchman M.D.

Sept 8, 1920 [Address] 2002 N. Fremont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge Cem. DATE OF BURIAL: Sept 10 1920

20-UNDERTAKER: Horner Burger & Son ADDRESS: 3641 Falls Road

6-9-19—H. P. Co.—1000 Eks.

46355 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46355

28

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1913 Alicanna ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emal Preib

(a) RESIDENCE. No. 1913 Alicanna ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. — mos. — ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Amelia Preib

7 DATE OF BIRTH (month, day, and year): Don't Know

AGE: about 70 Years — Months: Don't Know — Days: Don't Know — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone Mason

(b) General nature of industry, business, or establishment in which employed (or employer): cutting stone

(c) Name of employer: John Kennedy

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Herman Preib

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs. Preib

(Address): 713 E. Lanvale St

15 Filed SEP 8 - 1920

16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 7th 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 5th, 1920, to Sept 7th, 1920, that I last saw him alive on Sept 6th, 1920, and that death occurred, on the date stated above, at 2 P.M. The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of Aug 27/20

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Evidence

(Signed) C. O. Schweitzer, M. D.

, 19 (Address) 534 Gilmor Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: Sept 10 1920

20 UNDERTAKER: William Cook — ADDRESS: 502 S. North Ave

...—6-9-19—H. P. Co.—1000 Bks.

D.46356 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46356

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1423 W Lombard ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Morrow

(a) RESIDENCE. NO. 1423 W Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 6 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~Widow of~~) Martha E. Morrow

6 DATE OF BIRTH (month, day, and year) March 29-1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	6	9	

8 OCCUPATION OF DECEASED 031

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Mt Clare Shops

(c) Name of employer Balt. & O. R. R. Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Patrick Morrow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Jane Lahmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Martha E. Morrow 1423 W. Lombard St.

15 Filed ... 1920 Robert P. Harrison, Registrar

Burial ~~Permit~~ Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1920

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1920 to Sept 7, 1920, that I last saw h... alive on Sept 6, 1920, and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Anaemia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Howard ... M. D.

Sept 9, 1920 (Address) 927 Mt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Sept 9 1920

20 UNDERTAKER William Cook

ADDRESS 502 E. North Ave

46357 HEALTH DEPARTMENT—CITY OF BALTIMORE 46357

CERTIFICATE OF DEATH. 29

1-PLACE OF DEATH Little Sisters of the Poor REGISTERED NO. C

CITY OF BALTIMORE: (No. ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy Myers

Residence in Baltimore: No. 700 McCabe Ave St.; Lafayette (yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH. May 21, 1850 (Month) (Day) (Year)

7-AGE, 70 yrs. 3 mos. 17 ds. If LESS than 1 day, hrs. or min.? 000

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George Brandon

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Mary Fails

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed Sept 8, 1920, 191 Robert P. Harrison Registrar.

Sept 8-1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 7th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Office record 191, to 191, that I saw her alive on Sept 5 1920, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of heart

Influenza (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(Duration) yrs. mos. ds.

(Signed) F. A. Warner M. D.

Sept 8, 1920 (Address) 1133 Valley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 7 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore DATE OF BURIAL, Sept 11, 1920.

20-UNDERTAKER William Cook ADDRESS 602 S Hanly Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.46358

46358

CERTIFICATE OF DEATH.

REGISTERED NO. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home 1913 N Regester St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry O Butler

(Residence in Baltimore: No. 1913 N Regester St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept 16, 1843
(Month) (Day) (Year)

7-AGE, 72 yrs. 11 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hiram Butler

(Address) 615 Bank

15- Rec'd. 8 1920 Robert P. Harrison, Burial Permit Clerk, Registrar. 191....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 7, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1916, to Sept 7 1920, that I saw h[illegible] alive on " 6 1920, and that death occurred, on the date stated above, at 6.40 m.

The CAUSE OF DEATH* was as follows:

Paralysis of Heart

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bright's Disease

(Duration) 1 yrs. mos. ds.

(Signed) C. C. Harris M. D.

9/17, 1920. (Address) 2600 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Sept 9, 1920

20-UNDERTAKER Wm T. Hartley

ADDRESS 815 N Washington St.

Nicolas Rakes

1046359

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046359

CERTIFICATE OF DEATH.

REGISTERED No. C 5 - 81

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 124 N. Colvin St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nicolas Rakes

(Residence in Baltimore: No. 124 N. Colvin St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) M

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 68 about yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Wool Picker
(b) General nature of industry, business, or establishment in which employed (or employer): Mill

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) .....

15- Filed SEP 9 - 1920, 191. ROBERT B KRAUTER Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fatty Arterio Sclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos Rice M. D.
(Coroner.)

Sept 9, 1920 (Address) 1637 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Asbury

DATE OF BURIAL, Sept 9, 1920

20-UNDERTAKER John W Henderson

ADDRESS 1301 E Monument

Dec.—6-9-19—H. P. Co.—1000 Bks.

946360

HEALTH DEPARTMENT—CITY OF BALTIMORE

946360

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital, ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Jackson

(a) RESIDENCE. No. 702 Tissue St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Isaac Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Cora Bibbs

(Address): 702 tissue St

Filed SEP 9 - 1920

ROBERT F. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1920, to Sept. 6, 1920, that I last saw her alive on September 5, 1920, and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Uterine Fibroid

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia

(Secondary) Cachexia (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? not as yet

What test confirmed diagnosis? By manual exam.

(Signed) J. A. Holden, M. D.

9/6/. 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	Sept 9 1920
20 UNDERTAKER	ADDRESS
John H Timms	538 Park

c.—6-9-19—H. P. Co.—1000 Bks.

146361

HEALTH DEPARTMENT—CITY OF BALTIMORE

146361

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2120 Hoest ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby. Rynkowski

(a) RESIDENCE. NO. 2120 Hoest ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 8-20

7 AGE Years Months Days If LESS than 1 day hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Adam Rynkowski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Sophia Sofus

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Adam Rynkowski
(Address) 2120 Hoest St

15 Filed SEP 9 - 1920 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1920, to Sept 8, 1920, that I last saw him alive on Sept 8, 1920, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Gibson M. D.

9/8/20 (Address) 801 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	September 9 1920
20 UNDERTAKER	**ADDRESS**
John M Weber	1803 Bank St

c.—6-9-19—H. P. Co.—1000 Bks.

946362

HEALTH DEPARTMENT—CITY OF BALTIMORE

946362

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

TY OF BALTIMORE: (No. 516 N. Vincent St. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marguerette Ida Miller

(a) RESIDENCE. NO. 516 N. Vincent St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 28th 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George N. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Inez Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Inez Edwards
(Address) 516 N. Vincent St. Balto. Md.

15 Filed SEP 9 - 1920 19 ROBERT P. BRAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/7/'20 19

17 I HEREBY CERTIFY, That I attended deceased from 9/7/'20, 19, to 9/7/'20, 19, that I last saw h or alive on 9/7/20, 19, and that death occurred, on the date stated above, at 9 am m.

The CAUSE OF DEATH* was as follows: over

Marasmus

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL Sept 9 1920

20 UNDERTAKER Sam'l. Chase Son

ADDRESS 1400 Mosher

Spec. 6-9-19—H. P. Co.—1000 Bks.

1046363

HEALTH DEPARTMENT—CITY OF BALTIMORE

1261046363.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Genl Hospital ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hulmer

(a) RESIDENCE. NO. Somerset Apts. University ST. Pkwy. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mary A Hulmer

6 DATE OF BIRTH (month, day, and year) Dec 26 - 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 1886

(b) General nature of industry, business, or establishment in which employed (or employer): Real Estate Broker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): " Do not know

12 MAIDEN NAME OF MOTHER: Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " Do not know

14 Informant: William R. Hulmer

(Address): 3204 Wilkens Ave

15 Filed SEP 9 - 1920 ROBERT E. LEAUTER Registrar

Burial Permit Given

CAUSE OF DEATH. See instructions on back. IMPORTANT. CAREFUL ATTENTION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8 1920.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 26, 1920, to Sept. 8, 1920, that I last saw him alive on Sept. 8, 1920, and that death occurred, on the date stated above, at 3 20 P m.

The CAUSE OF DEATH* was as follows:

Uraemia. Over

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Hypertropy of Prostate

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of Aug. 27 - 1920

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Manifestations.

(Signed) R. N. Richardson, M. D.

, 19 (Address) Md. Genl Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Sept 10 1920
20 UNDERTAKER	ADDRESS
J. Kemp Bartlett & Son	

D46364

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46364

64

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 805 N. Stricker ST.) 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Wiley

(Residence in Baltimore: No. 817 N. Stricker St.) 70 yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, December 2, 1849
(Month) (Day) (Year)

7-AGE, 71 yrs. mos. da. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired 086
(b) General nature of industry, business, or establishment in which employed (or employer) Manager of shirt factory

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, John Wiley

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Eliz. Davis

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Weeks

(Address) 817 N. Stricker

15- SEP 9-1920 ROBERT E KRAUTER

Filed....., 191.....

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 7, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Jur
(Inquest, au
enquiry find that said deceased came to his death
topsy or inquiry.)
on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) yrs. mos. da.

(Signed) J. T. Hennessy M. D.
(Coroner)

Sept. 8, 1920 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Sept. 9, 1920

20-UNDERTAKER John O. Whitelock ADDRESS 130 W. Fayette St

important. See instructions on back of Certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0 46365 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 0 46365

CERTIFICATE OF DEATH.

REGISTERED NO. 384

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME India Morris

(a) RESIDENCE. No. 1403 E. May St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	~	~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Factory work

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) New City Hospital.

15 FILED SEP 9- 1920 ROBERT B [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7, 1920

17 I HEREBY CERTIFY, That I attended deceased from September 4. 1920 to September 7. 1920. that I last saw her alive on September 7, 1920. and that death occurred, on the date stated above, at 11:05 A.m.

The CAUSE OF DEATH* was as follows:

Ulcerative colitis
(etiology undetermined)

(duration) yrs. 2. mos. ds.

CONTRIBUTORY (Secondary) Chronic fibroid pulmonary tuberculosis. (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) V Bottsman, M. D.

9/7/. 1920 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cmtry	Sept 10 1920
20 UNDERTAKER	ADDRESS 1725
Mrs Roberta Elliott	Oakland cm

Spec. 6-9-19—H. P. Co.—1000 Bks.

1046366 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046366

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 N. Fulton Ave. WARD 20)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Margaret Tanner

(a) RESIDENCE. NO. 310 N. Fulton Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: E. Ernest Tanner

6 DATE OF BIRTH (month, day, and year): 1845

7 AGE: 75 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Wentzel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Mary King

(Address): 310 N Fulton Ave

15 Filed SEP 9 - 1920 ROBERT F KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 7 1920

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1920, to Sept. 7, 1920, that I last saw her alive on Sept. 6, 1920, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Cardiac paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stethoscope

(Signed) John C Powell, M. D.

9-7, 1920 (Address) 904 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

DATE OF BURIAL: Sept 10 1920

20 UNDERTAKER: F.A. Krause & Son

ADDRESS: 703 Hanover

...cc.—6-9-19—H. P. Co.—1000 Bks.

046367

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 046367

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. # 1117 Hanover ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary D Kleinman

(a) RESIDENCE. NO. 1117 Hanover ST., 23 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John D Kleinman

6 DATE OF BIRTH (month, day, and year) Sept 9, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Servant Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Joseph Kopfer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Irma Zeller

(Address) 117 Hanover St

15 Filed SEP 9 - 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 5 1920, to Sept 7 1920, that I last saw her alive on Sept 7 1920, and that death occurred, on the date stated above, at 10 0 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Congestion

0332

(duration) yrs. 1 mon. ds.

CONTRIBUTORY (Secondary) Acute Intoxication

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W Hammerbacher, M. D.

Sept 8 1920 (Address) 681 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Sept 9 1920
20 UNDERTAKER	ADDRESS
H A Kane & Son	1330 Hanover

046368 HEALTH DEPARTMENT—CITY OF BALTIMORE 1

CERTIFICATE OF DEATH.

1820 046368

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Albemarle St & Post Hospital ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evert K. Jenitsen

(Residence in Baltimore: No. Admiralty Service St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 21 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seaman
(b) General nature of industry, business, or establishment in which employed (or employer): USN

9-BIRTHPLACE, (State or Country), South Africa

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Holland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Holland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E Monroe

(Address) 1 N Pt Boulevard

15- Filed SEP 9 - 1920 191.... ROBERT E LEAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 4, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Lob
Fatal bullet wound of head
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward Stark Smith M. D.
(Coroner)
9/8, 191 (Address) 1600 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery — DATE OF BURIAL, Sept 9. 1920

20-UNDERTAKER D. Gunnor & Bro — ADDRESS 1127 E Balto st

Important: Entries must be made in ink.

Gillian M. McConnell. 1046369

c.—6-9-19—H. P. Co.—1000 Bks.

1046369

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hos. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Gillian Mabel McConnell

(a) RESIDENCE. NO. 2019 Hilton ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Aubrey McConnell

6 DATE OF BIRTH (month, day, and year) Feby 19 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer Yourself

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Storm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Katherine Müller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Husband 2019 Hilton Ave

15 Filed SEP 9- 1920 Registrar

ROBERT F. FAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 6 1920 to Sept 7 1920

that I last saw her alive on Sept 7 1920

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Orbital abscess

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pansinusitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Sept 7, 1920

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) Howard B. McClure M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Sept 11 19 20

20 UNDERTAKER J. F. Sheckells Son

ADDRESS Md. Pa.

1046370 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046370

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1163 E Lombard St. 3 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aaidor Capolonte

(Residence in Baltimore: No. 1163 E Lombard St. 3 St., 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	S

6-DATE OF BIRTH, Sept 9, 1918
(Month) (Day) (Year)

7-AGE, 8 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country). Baltimd

PARENTS.

10-NAME OF FATHER, Joe Capolonte

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Dina Levy

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Balt St

15- SEP 9-1920 Filed ..... 191.....

ROBERT E KRAUTER Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~investigation~~ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~investigation~~ (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of left leg

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

Signed) P H Ehrlich M. D.

Sept 9 1920 (Coroner) (Address) 1100 N Eden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Lebanon Carmel	Sept 9, 1920

20-UNDERTAKER Jack Lewis ADDRESS 1411 E Pleasant

...c.—6-9-19—H. P. Co.—1000 Bks.

046371 HEALTH DEPARTMENT—CITY OF BALTIMORE 046371

CERTIFICATE OF DEATH. + 123

REGISTERED NO.

1-PLACE OF DEATH

...ITY OF BALTIMORE: (No.) Johns Hopkins Hosp ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Bockins

(a) RESIDENCE. No. 1310 N. Charles St.

(Usual place of abode)

WARD. Marion Indiana

Length of residence in city or town where death occurred ...yrs. 4 mos. ...ds. How long in U. S., if of foreign birth? ...yrs. ...mos. ...ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 25-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	50		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Speculator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Chas J. Bockins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Ella Garlick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mich.

14 Informant Hospital Record (Address) J.H.H.

15 Filed SEP 9 - 1920 ROBERT F. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9th 1920

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1920, to Sept 9th, 1920, that I last saw h... alive on Sept 9th, 1920, and that death occurred, on the date stated above, at 7.20 a m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis - resulted from renal calculus.

(duration) ...yrs. ...mos. 7 7 ds.

CONTRIBUTORY (Secondary) Renal calculus left 14 years. Renal calculus right 74 days.

(duration) 1 4 yrs. ...mos. 74 ds.

18 Where was disease contracted if not at place of death? First attack June previous

Did an operation precede death? Yes Date of Aug 26-20

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Maynard K. Cecil, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Hill. DATE OF BURIAL: 9/9/20

20 UNDERTAKER: G F Walker ADDRESS: 723 W Lafayette Av

Spec.—8-24-14—M. & T.—2000 Bks.

046372 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D46372

28

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1223 Gilmor ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lydia Mc Elderry (Mrs Joseph)

(Residence in Baltimore: No. 1223 N. Gilmor St.; 75 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July 17 (Month) (Day), 1845 (Year)

7-AGE, 25 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE, (State or Country). Delaware

PARENTS.

10-NAME OF FATHER. Walter H. James

11-BIRTHPLACE OF FATHER (State or Country). England

12-MAIDEN NAME OF MOTHER. Mary Grafton

13-BIRTHPLACE OF MOTHER (State or Country). Philadelphia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. James

(Address) 1223 N. Gilmor St.

15- SEP 9 - 1920 Filed ..... 191..... ROBERT A KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 8 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 15 1920, to Sept 8 1920, that I saw her alive on Sept. 7 1920, and that death occurred, on the date stated above, at 7a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Charles G. Clark M. D.

Sept 9, 1920 (Address) 1306 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Western Cemetery DATE OF BURIAL, Sept 10 1920

20-UNDERTAKER Henry Lutz ADDRESS 1007 N. Bond

...c.—6-9-19—H. P. Co.—1000 Bks.

D46373

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46373

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 17th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Joseph Smith

(a) RESIDENCE. NO. 1614 Guilford ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9th 1899.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None ffo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jose C. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Julia Lorazy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Records of Mt Hope Retreat Baltimore Md -

15 Filed SEP 9 - 1920 19 ROBERT R KRAUTER Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 19 20

17

I HEREBY CERTIFY, That I attended deceased from Sept 13th, 1920, to Sept 7, 19 20, that I last saw him alive on Sept 7, 19 20, and that death occurred, on the date stated above, at 11. P. m.

The CAUSE OF DEATH* was as follows:

Pericarditis

Acut (duration) 0 yrs. 2 mos. 0 ds.

CONTRIBUTORY (Secondary) Anemia Since Birth (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank Flaming, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Sep. 10 1920
20 UNDERTAKER	ADDRESS
E J Fanning & Son 1938	E Lafayette

046374 HEALTH DEPARTMENT—CITY OF BALTIMORE 046374

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2116 Eagle ST. 20 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Eddelstein

(Residence in Baltimore: No. 2116 Eagle St.: 4410 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	married

6-DATE OF BIRTH, July 20, 1877 (Month) (Day) (Year)

7-AGE, 31 yrs. 2 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Morris Foss

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Fannie Patlek

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Phillip Eddelstein

(Address) 2114 Eagle St

15- SEP 9 - 1920 ROBERT F. KRAUTER Burial Permit Clerk

Filed....., 191... Registrar.

important. See instructions for use.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) yrs. 1 mos. ds.

(Signed) James M. Fenton M. D. (Coroner.)

Sept 9, 1920 (Address) 700 E. Eager St.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
[illegible] Mount Zion	Sept 10 '20

20-UNDERTAKER Jack Sears ADDRESS 1911 E Balto

c.—6-9-19—H. F. Co.—1000 Bks.

946375 HEALTH DEPARTMENT—CITY OF BALTIMORE 946375

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

ITY OF BALTIMORE. (No. 1429 Baltimore ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia S Briggs

(a) RESIDENCE. No. 1429 Baltimore ST. 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 5 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Arthur L Spriggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Edna Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Arthur L Spriggs
(Address) 1429 Baltimore

15 Filed SEP 9 - 1920 Received ROBERT B KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 — 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1920, to Sept 6, 1920, that I last saw h— alive on Sept 6, 1920, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm Hammond Hagner, M. D.

Sept. 7 1920 (Address) 631 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	9/9 1920
20 UNDERTAKER	ADDRESS
M. J. Tabler & Sons	318 Light St

c.—6-9-19—H. P. Co.—1000 Blks.

46376 D 46376

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 212 W Chase ST.; 11 WARD)

2-FULL NAME Rosa Bush

(a) RESIDENCE. No. 212 W Chase ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE 43 Years — Months — Days —

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer): Home Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Born in Baltimore

PARENTS

10 NAME OF FATHER Edgar Bush

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Rosie Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): born in Md

14 Informant Rosie Bush (Address) 212 Chase St

15 Filed SEP 9 - 1920 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-7- 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1920, to Sept 7, 1920, that I last saw h[illegible] alive on Sept 7, 1920, and that death occurred, on the date stated above, at 730 A m.

The CAUSE OF DEATH* was as follows:

Brights Disease
Heart failure

(duration) yrs. 3 mos. 1 ds.

CONTRIBUTORY (Secondary) Brights disease

(duration) yrs. 3 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D H W Kammacher M. D.

19 (Address) 7 W Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ant-Asurium Cem — DATE OF BURIAL: Sept-9 1920

20 UNDERTAKER: Mrs R A Elliott — ADDRESS 1725 Ashland Ave

c.—6-9-19—H. P. Co.—1000 Bks.

1046377 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046377

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE (NO. 3300 O'Donnell ST., 26 WARD)

2-FULL NAME John H Stickline

(a) RESIDENCE. NO. 3300 O'Donnell ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Mary E. Stickline

6 DATE OF BIRTH (month, day, and year): Jan 27, 1877

7 AGE — Years: 43 — Months: 7 — Days: 11 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Brewer 043

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: G. B. S. Brewing Co. Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER: Adam Stickline

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Eva Klop.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary E. Stickline

(Address): 3300 O'Donnell St.

15 Filed: SEP 9 - 1920 " ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 7 1920

17 I HEREBY CERTIFY, That I attended deceased from 3/9/20, 19..., to 9/7, 19 20, that I last saw h im alive on 9/7, 19 20, and that death occurred, on the date stated above, at 7.05 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Tuberculosis

(duration) ? yrs. 5 mos. 28 ds.

CONTRIBUTORY (Secondary): Tuberculosis

(duration) ? yrs. 5 mos. 28 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Endowed.

(Signed) J. H. McGurell M. D.

19 (Address) 633 - S - 3rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn Cemetery — DATE OF BURIAL: Sept. 11 1920

20 UNDERTAKER: Zukert & Zukert — ADDRESS: 1739 E. Eager

Spec.—5-19-13—M. & T.—500 Bks.

046378

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 046378

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 East 31st ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Elizabeth S Utermohlen

(Residence in Baltimore: No. 317 East 31st St.; 60 yrs., ~~2~~ mos. ~~7~~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widowed

6-DATE OF BIRTH, July 7, 1843 (Month) (Day) (Year)

7-AGE, 77 yrs. 2 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Wales.

PARENTS.

10-NAME OF FATHER, John O Davis

11-BIRTHPLACE OF FATHER (State or Country), Wales

12-MAIDEN NAME OF MOTHER Elizabeth Oliver

13-BIRTHPLACE OF MOTHER (State or Country), Wales

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Chas Brown

(Address) 317 E 31st

15-

Filed SEP 9 - 1920 191 ROBERT B KRAUTER Registrar.

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 9, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 2 1920, to Sept 9 1920, that I saw h[illegible] alive on Sept 9 1920, and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cirrhosis Pulmonis

(Duration) 5 yrs. mos. ds.

(Signed) H. L. Polock M. D.

....., 191... (Address) 728 N Monroe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, 9/11, 1920

20-UNDERTAKER Chas S Evans & Son ADDRESS 118 W Mt Royal ave

046379 HEALTH DEPARTMENT—CITY OF BALTIMORE 046379

CERTIFICATE OF DEATH.

167

REGISTERED NO. C...

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin & Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H. Bush

(Residence in Baltimore: No. 1609 W Lombard St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May (Month) 13 (Day), 1858 (Year)

7-AGE	If LESS than 1 day,
62 yrs. 3 mos. 24 ds.	....hrs. or....min.?

8-OCCUPATION: 030
(a) Trade, profession, or particular kind of work: R.R. Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): B+O R.R.

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thomas Bush

11-BIRTHPLACE OF FATHER (State or Country), England Maryland

12-MAIDEN NAME OF MOTHER Eush

13-BIRTHPLACE OF MOTHER (State or Country), Eush

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Bush

(Address) 1609 W Lombard St

15-

Filed SEP 9-1920 191 ROBERT E KRAUTER Registrar

BURIAL PERMIT

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 8 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows)

Jumps over Counter Part of his body and to Back fire explosion or engine accident (Duration) ....yrs. ....mos. 1/3 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ....yrs. ....mos. ....ds.

(Signed) James H Lembo M. D. (Coroner.)

Sept 9, 1920 (Address) 200 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1/3 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Mt Clare Yard B+O R.R.

Former or usual residence 1609 W Lombard St

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
London Park	Sept 11, 1920
20-UNDERTAKER	ADDRESS
Jos B Cook	1003 W Baltimore

Important—Use Indelible Pencil

c.—6-9-19—H. P. Co.—1000 Blks.

1046380 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046380

CERTIFICATE OF DEATH.

X 28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Hillsdale Ind St.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elwood Milton McKenzie

(a) RESIDENCE. No. Hillsdale Ind ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? 22 yrs. 1 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mildred S. McKenzie

6 DATE OF BIRTH (month, day, and year) July 13. 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Slubber Tender in 086

(b) General nature of industry, business, or establishment in which employed (or employer) Cotton Mills

(c) Name of employer Gilbertol Cotton Co Alberton Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Elisha McKenzie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER Nora V. Lutz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Co Md

14 Informant Mrs Nora V McKenzie
(Address) Hillsdale Md

15 Filed SEP 9- 1920 ROBERT F. LEAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 24 1920, to Sept 7 1920, that I last saw him alive on Sept 7 1920, and that death occurred, on the date stated above, at 7 25 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. 9 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo L Everhart, M. D.

. 19 (Address) Woodlawn Va

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Good Shepherd (Rockland) Baltimore Co Md	Sept 9 1920

20 UNDERTAKER J & B Cook

ADDRESS 103 W Balto

ec.—6-9-19—H. P. Co.—1000 Bks.

D46381

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46381

CERTIFICATE OF DEATH.

REGISTERED NO. 40

1-PLACE OF DEATH Bayview Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. ..... ST.: 19 WARD)

2-FULL NAME Mary Ann Dougherty.

(a) RESIDENCE. No. 1510 W. Baltimore ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Emanuel E. Dougherty

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penna.

PARENTS

10 NAME OF FATHER: Jacob Fautz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna.

14 Informant (Address): Bayview Hospital Baltimore Md.

15 Filed SEP 9 - 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8, 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1920, to Sept 8, 1920.

that I last saw h.. alive on Sept 8, 1920 and that death occurred, on the date stated above, at 9.20 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerotic Brain Disease (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) N. Goldsmith M. D.

9/8/ 1920 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltic Cmetry	Sept 10 1920
20 UNDERTAKER	ADDRESS
Robert S. Brookeman	Hollins Baltimore

Spec.—8-24-14—M. & T.—2000 Blks.

46382 HEALTH DEPARTMENT—CITY OF BALTIMORE 46382

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 119 Elm St - Curtis Bay ST.; (WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josef Zapotocky Jr

(Residence in Baltimore: No. 119 Elm St - St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept 7 1920
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 1 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... —
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Curtis Bay

PARENTS.

10-NAME OF FATHER, Josef Zapotocky

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER, Antoni Kopacek

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Josef Zapotocky

(Address) C Bay

15-

SEP 9-1920 Filed ....., 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 7 1920, to Sept 8, 1920, that I saw h alive on Sept 7 1920, and that death occurred, on the date stated above, at 5.00 p.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B Norton M. D.

Sept 9 1920 (Address) Curtis Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemetery DATE OF BURIAL, Sept 9 1920

20-UNDERTAKER F. Crockett Jr ADDRESS C Bay

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46383

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46383

CERTIFICATE OF DEATH.

114-991 Pinzivalli

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Poolelare Pinzivalli

(a) RESIDENCE. NO. 302 South High St. ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Joseph Pinzivalli

6 DATE OF BIRTH (month, day, and year): June 10 1869

7 AGE: Years 50 Months 2 Days 28 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Tony Poolelare

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Annie Knopsa

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Joseph Pinzivalli 302 S High St

Filed ... 19 ... Robert P. Harrison, Registrar

SEP 9 - 1920

Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 31, 1920, to Sept. 8, 1920

that I last saw her alive on Sept. 8, 1920

and that death occurred, on the date stated above, at 11:10 A.m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

(Secondary) (duration) yrs. mos. ds.

CONTRIBUTORY Bronchio-pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept. 2, 1920

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) ... M. D.

19 .. (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents

DATE OF BURIAL: Sept 11 1920

20 UNDERTAKER: Wendell D Offel & Son

ADDRESS: 37 S Hanover

Spec.—8-24-14—M. & T.—2000 Bks.

46384 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46384

50

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 E. Cross St. St. 24 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Schulz.

(Residence in Baltimore: No. 113 E. Cross St St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feby 21st, 1858
(Month) (Day) (Year)

7-AGE, 62 yrs. 7 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Wife.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Rolloff.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John D. Schulz.

(Address) 113 E. Cross St.

15. SEP 9-1920 Filed....., 191.....

Robert P. Harrison, Registrar.
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 7, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Sept 7 1920, that I saw h~ alive on Sept 7 1920, and that death occurred, on the date stated above, at 9.30 m.

The CAUSE OF DEATH* was as follows:

Embolism of Femoral Artery

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene

(Duration) yrs. mos. 7 ds.

(Signed) [illegible] M. D.

Sept 9, 1920 (Address) 821 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Sept. 10, 1920

20-UNDERTAKER Maryard D. Flynn

ADDRESS 142 W Light St.

Spec.—8-24-14—M. & T.—2000 Bks.

0.46385 HEALTH DEPARTMENT—CITY OF BALTIMORE D46385

CERTIFICATE OF DEATH.

REGISTERED NO. C 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 Race St. St.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Ernst.

(Residence in Baltimore: No. 1613 Race St St.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August 21, 1918 (Month) (Day) (Year)

7-AGE, 2 yrs. 1 mos. 18 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles Ernst

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Nettie Kohn

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nettie Ernst

(Address) 1613 Race St.

15- SEP 9-1920 Filed, 191 Robert P. Harrison, Registrar. Burial Permit C

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 9th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 3rd, 1920, to September 9th, 1920, that I saw h[illegible] alive on September 8th 1920, and that death occurred, on the date stated above, at 5 30 m. A m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) D Hass Mendel M. D.

Sept. 9 1920 (Address) 924 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, Sep. 10, 1920.

20-UNDERTAKER Margaret G. Flynn ADDRESS 1472 Light St

Rev. 6-9-19—H. P. Co.—1000 Blks.

0.46386 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.46386

0.46386 CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH Aged Women's Home

CITY OF BALTIMORE: (No ~~Annie R. Shroff~~ ST.: 19 WARD)

2-FULL NAME Annie R Shroff

(a) RESIDENCE. No 1400 N Lexington ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Wht	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	1	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country): Harford Co Md

10 NAME OF FATHER: Joseph W. Shroff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lancaster Co. Pa.

12 MAIDEN NAME OF MOTHER: Sarah Reston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co. Md.

14 Informant: Florence B. Diffenbaugh
(Address): Aged Women's Home

15 Filed SEP 9 - 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

TION is very important. See instruc-

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1920

17
I HEREBY CERTIFY, That I attended deceased from June, 19 20, to Sept 7, 19 20,
that I last saw h alive on Sept 7, 19 20,
and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma
Cancer

		(duration)	yrs.	mos.	ds.
I		Unknown			
CONTRIBUTORY (Secondary)		Senile Atrophy			
		(duration)	yrs.	3 mos.	ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? None

What test confirmed diagnosis?

(Signed) F Norwood, M. D.

. 19 (Address) 93 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	Sept 10 1920
20 UNDERTAKER: George J Smith	ADDRESS: 1000 W Fayette St

Dec.—6-9-19—H. P. Co.—1000 Bks.

046387

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46387

CERTIFICATE OF DEATH.

108

REGISTERED NO.

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. Franklin Square Hospital, 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. Lee

(a) RESIDENCE. No. 1723 W. Franklin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 10 mos. 10 ds. How long in U. S., if of foreign birth days yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 2 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanist

(b) General nature of industry, business, or establishment in which employed (or employer) 131

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER James F. Lee

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Agnes P. Bichell

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Agnes P. Lee
(Address) 1725 Franklin St

15 Filed SEP 9 - 1920 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1920, to Sept 8, 1920, that I last saw him alive on Sept 8, 1920 and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendicitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diffuse peritonitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/4/20

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Lyman D. Gibbett, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 10 1920
20 UNDERTAKER George J. Smith	ADDRESS 1000 W. Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

46388

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.46388

CERTIFICATE OF DEATH.

104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3136 Remington Ave. ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernice Joyce Charbonnet

(Residence in Baltimore: No. 3136 Remington Ave. St.; ....yrs., 8 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec. 4, (Month) (Day) 1912. (Year)

7-AGE, ...yrs. 8 mos. 24 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Irwin J Charbonnet

11-BIRTHPLACE OF FATHER (State or Country), Louisiana

12-MAIDEN NAME OF MOTHER Bernice B Alestire

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irwin J. Charbonnet

(Address) 3136 Remington Ave.

15-

Filed SEP 9 - 1920, 191....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 8, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 7 1920, to September 8 1920, that I saw her alive on September 8 1920, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Acute Ileocolitis

(Duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. J. Davies M. D.

9-17, 1920 (Address) 700 W 33rd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL. Sept. 10, 1920.

20-UNDERTAKER E. Le Roy Hoffler

ADDRESS 125 E North Ave

...—6-9-19—H. P. Co.—1000 Bks.

46389

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 D 46389

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Wilkins Ave ST.: [illegible] WARD)

2-FULL NAME Baby Bachelman

(a) RESIDENCE. No. 1822 W Mulberry ST., MC WARD. ~~Md.~~

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 8th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ferdinand W. Bachelman

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Mae Ermiger

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Ferdinand W. Bachelman
(Address) 1822 W. Mulberry st

15 Filed SEP 10 1920 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1920, to Sept 9th, 1920, that I last saw h~~im~~ alive on Sept 9, 1920, and that death occurred, on the date stated above, at 10:15 A m.

The CAUSE OF DEATH* was as follows:

Difficult Forceps Delivery

... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Labotatory

(Signed) E. P. Greenawalt M. D.

. 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Sept 10th 1920
20 UNDERTAKER E Sachs and Son	ADDRESS 1034 Monroe st

...ec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46390 ✓ D46390

CERTIFICATE OF DEATH.

14 120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 546 Baker ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Mathinas Glascoe

(a) RESIDENCE. NO. 546 Baker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE 51 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Waldorf Charles Co. Maryland

PARENTS

10 NAME OF FATHER Phillip Gillum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Waldorf Mass. Co. Maryland

12 MAIDEN NAME OF MOTHER Emily Wade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles Co Maryland

14 Informant William E Glascoe

(Address) 546 Baker St

15 Filed SEP 10 1920 19 [illegible] Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/9 1920

17 I HEREBY CERTIFY, That I attended deceased from 9/9 1920, to 9/9 1920, that I last saw h[illegible] alive on 9/9 1920, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Interstitial nephritis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Brown H. Grove, M. D.

, 19 (Address) 1206 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Waldorf Station Mass. Co. Md.	Sept. 11 1920

20 UNDERTAKER Joseph A Farrell

ADDRESS 2514 Division St

Spec.—8-24-14—M. & T.—2000 Blks.

046391 HEALTH DEPARTMENT—CITY OF BALTIMORE 046391

CERTIFICATE OF DEATH.

105

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1400 Park Ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bethiah Hendricks

(Residence in Baltimore: No. 1400 Park ave. St.; 4yrs. ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED?~~ (Write the word.) Single

6-DATE OF BIRTH, ... (Month) — (Day) — (Year) 1851.

7-AGE 69 yrs. ...mos. ...ds. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Keeping
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Thomas Hendrick

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Bethiah —

13-BIRTHPLACE OF MOTHER (State or Country), Balt.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Geo B Morse.

(Address) 1400 Park Ave.

15- SEP 10 1920 ROBERT J REUTER Registrar.
Filed ..... 191. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8, 1920 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Aug 19 1920, to Sept 8 1920, that I saw h[illegible] alive on Sept 7 1920, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows: Acute Entro Colitis

..... (Duration) ...yrs. ...mos. 3 ds.

CONTRIBUTORY (Secondary) Angina - Toxaemia nourished.

..... (Duration) ...yrs. ...mos. ...ds.

(Signed) John A Cairns M. D.

....., 191... (Address) 101 N Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Sept. 10, 1920

20-UNDERTAKER John J Mitchell — ADDRESS 128 W Fayette St

...c.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46392 D46392

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3136 Remington Ave WARD 17)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma. Baird Charbonnett

(a) RESIDENCE. No. 3136 Remington Ave. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Femal	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-14 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Irwin J Charbonnet

11 BIRTHPLACE OF FATHER (city or town) (State or country) Louisiana

12 MAIDEN NAME OF MOTHER Bernice Abshire

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Irwin J Charbonnet
(Address) 3136 Remington Ave

15 Filed SEP 10 1920 19 ROBERT ... TER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1920, to Sept 10, 1920, that I last saw her alive on Sept 10, 1920, and that death occurred, on the date stated above, at 320 A. m.

The CAUSE OF DEATH* was as follows:

Acute Ileocolitis

(duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. J Davies, M. D.

Sept 10 1920 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Sept 11 1920
20 UNDERTAKER	ADDRESS
E Le Roy Stiffler	1245 North Ave

...—6-9-19—H. P. Co.—1000 Blks.

Jenney Johnson.

046393.

HEALTH DEPARTMENT—CITY OF BALTIMORE

046393

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1108 Woodyear ST.: 16 WARD)

2-FULL NAME Jenney Johnson

(a) RESIDENCE. NO. 1108 Woodyear ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed or Divorced (write the word): widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Robert Johnson

6 DATE OF BIRTH (month, day, and year) Oct. 26, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	10	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Essex Co. Va

PARENTS

10 NAME OF FATHER No information

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER No information

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Mary Hayes
(Address) 1108 Woodyear St

15 Filed SEP 10 1920 ROBERT B. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/9/ 1920

17 I HEREBY CERTIFY, That I attended deceased from 9/5/ 1920, to 9/9/ 1920, that I last saw her alive on 9/8/ 1920, and that death occurred, on the date stated above, at 3.00 A. m.

The CAUSE OF DEATH* was as follows:

Total Paralysis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hemiplegia (duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. B. Hawkins, M. D.

9/9/ 1920 (Address) 1216 D. H. Bld.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bailys wharf Essex Co Va — DATE OF BURIAL: SEP 10 1920

20 UNDERTAKER: JAMES H. DENNIS — ADDRESS: 1303 PRESTMAN ST.

Dec.—6-9-19—H. P. Co.—1000 Bks.

1046394 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046394

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Beidler Sellman Ave ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl S. Kemper

(a) RESIDENCE. No. 1462 William ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis H. Kemper.

6 DATE OF BIRTH (month, day, and year) Feb 25 1890

7 AGE • Years	Months	Days	If LESS than 1 day, hrs. or min.
30	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John E Elliott.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sarah E Hammitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Francis H. Kemper.

(Address) 1462 William St.

15 Filed SEP 10 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/7 1920

17 I HEREBY CERTIFY, That I attended deceased from 3/27/20, 19..., to 9/7, 1920.

that I last saw her alive on 9/7, 1920.

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Colonic)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9/4/20

Was there an autopsy? no

What test confirmed diagnosis? Exploratory operation

(Signed) Philip B. Fowler, M. D.

9/7, 1920 (Address) 1432 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon P.K. Cem.	9-10 1920
20 UNDERTAKER	**ADDRESS**
E and B Harle	115 E West St

Dec.—6-9-19—H. P. Co.—1000 Bks.

046395 HEALTH DEPARTMENT—CITY OF BALTIMORE 046395

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 Homewood Ave 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Meyers

(a) RESIDENCE. No. 1022 Homewood Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Meyers

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About	49 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster 073

(b) General nature of Industry, business, or establishment in which employed (or employer) Geo. A Hart Co

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Minnie Meyers

(Address) 1022 Homewood Ave

Filed SEP 10 1920 ROBERT B. CRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1920.

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1920, to Sept 9, 1920, that I last saw h[illegible] alive on Sept 8, 1920, and that death occurred, on the date stated above, at 6:25 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John D. Ford M. D.

9/10, 1920 (Address) 936 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept. 11 1920
20 UNDERTAKER Penny Hoeck Sons	ADDRESS 130 E Eager

ec.—6-9-19—H. P. Co.—1000 Bks.

046396

HEALTH DEPARTMENT—CITY OF BALTIMORE

046396

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St., 26 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace P. Williams

(a) RESIDENCE. No. Bay View Asylum St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Samuel S. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary S. Tucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records Address M. T. H.

SEP 10 1920

15 Filed . 19 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9, 1920

17

I HEREBY CERTIFY, That I attended deceased from July 9, 1920, 19..., to Sept. 9, 19 20,

that I last saw h im alive on Sept. 9, 19 20,

and that death occurred, on the date stated above, at 6.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Spontaneous hydropneumothorax (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. J. Rigney, M. D.

9-19-20 Address Municipal Tho. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C. Ger	Sept 12 20
20 UNDERTAKER Colt & Turner	ADDRESS 1X X 2nd St

Spec.—8-24-14—M. & T.—2000 Bks.

046397 HEALTH DEPARTMENT—CITY OF BALTIMORE 046397

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 E. Eager St.; 1 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Parr

(Residence in Baltimore: No. 1628 E Eager St.; 5/12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, March 17, 1852
(Month) (Day) (Year)

7-AGE, 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Mgr.
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Dalsund

PARENTS.

10-NAME OF FATHER, Michael Parr.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Eva Pittner

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Hamilton

(Address) 1628 E Eager

SEP 10 1920 ROBERT B KRAUTER

Filed ....., 191.. BURIAL PERMIT Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 9, 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19th 20 to Sept 9th 20, that I saw h or alive on Sept 9th 20, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) yrs. mos. ds.

(Signed) J. C. Stine M. D.

Sept 10, 191.. (Address) 1501 E Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery DATE OF BURIAL, Sept 13 1920

20-UNDERTAKER Todd & Johnson ADDRESS 1422 N. Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046398 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046398

CERTIFICATE OF DEATH. X 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 323 S. Stricker ST. 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cameron Alexandria Mooney

(a) RESIDENCE. NO. 323 S. Stricker ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10-1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alexandria, Va.

PARENTS

10 NAME OF FATHER Oscar T. Mooney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charlottesville, Va

12 MAIDEN NAME OF MOTHER Beulah May Fitzwater

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Timberville, Va

14 Informant Georg[illegible] Fitzwater

(Address) 323 S. Stricker st

15 Filed SEP 10 1920 ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to Sept 8, 1920, that I last saw him alive on Sept. 8, 1920, and that death occurred, on the date stated above, at 8:15 p m.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteric intoxication

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Acute otitis media

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no [physical findings Symptoms and

What test confirmed diagnosis?

(Signed) W. N. Triplett, M. D.

, 19 (Address) 1324 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	Sept 10 1920
20 UNDERTAKER	ADDRESS
A Jones	207 S Stricker

TION is very important.

D46399 HEALTH DEPARTMENT—CITY OF BALTIMORE D46399

CERTIFICATE OF DEATH. 103

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 649 S Curley St.: 1 WARD) REGISTERED NO. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin Integrated

(Residence in Baltimore: No. 649 S Curley St St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Aug (Month) 28 (Day), 1918 (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, James Fitzgerald

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Emma Kuffel

13-BIRTHPLACE OF MOTHER (State or Country). Balt Md

14-THE ABOVE IS TRUE TO THE ~~BEST OF MY KNOWLEDGE~~.

(Informant) James Fitzgerald

(Address) 649 S Curley St

15- SEP 10 1920 COUNTY [illegible]

Filed ....., 191... Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 9 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Cardiac Gastritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

9/10, 1920 (Address) 1800 Chapel St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery

DATE OF BURIAL, Sept 11, 1920

20-UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E. Eager St.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46400

CERTIFICATE OF DEATH.

19 D 46400

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2506 Madison Ave St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Kaufman

(a) RESIDENCE. No. 2506 Madison Ave St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female

4 COLOR OR RACE White

5 ~~Single, Married, Widowed,~~ or ~~Divorced~~ (write the word) Widow

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) WIFE of Emanuel L. Kaufman

6 DATE OF BIRTH (month, day, and year) Not known 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF ~~FATHER~~ Jacob Gundersheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Leal Kaufmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fred Kaufman

(Address) 301 N Eutaw

15 Filed SEP 10 1920 19 ROBERT E. ARMSTRONG Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb, 1911, to Sept 9, 1920.

that I last saw h alive on Sept 9, 1920

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual phys. signs

(Signed) Harry Adler, M. D.

, 19 (Address) 1710 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Hebrew	9-10-20
20 UNDERTAKER David Sondheim	ADDRESS 118-20 W. Pratt Royal

TION is very important. See instructions

D4640 HEALTH DEPARTMENT—CITY OF BALTIMORE D4640

CERTIFICATE OF DEATH.

175-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther Puttik

(Residence in Baltimore: No. 837 Ashland Ave. St.; 3 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	white	S

6-DATE OF BIRTH, Sept. 8, 1917.
(Month) (Day) (Year)

7-AGE, 3 yrs. mos. da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Joseph Puttik

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rebecca Miller

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Baltimore

15- SEP 10 1920 191... ROBERT J. KRAUTER Registrar. Burial Permit Clerk

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 8, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an August, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said August (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident
Multiple Contusions & Shock.
(Duration) hrs. mos. 3 hrs ds

CONTRIBUTORY (Secondary) Asthma
(Duration) 15 yrs. mos. 3 hrs ds.

(Signed) Jno Claude Blado M. D.
(Coroner.)
9/10/20, 191... (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Workmens circle Park	9-10, 1920
20-UNDERTAKER Jack Lewis	ADDRESS 1411 E Balto

D 46 402 HEALTH DEPARTMENT—CITY OF BALTIMORE D 46 402

CERTIFICATE OF DEATH.

79c

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2837 Bernard ST.: 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Della F. Fitzpatrick

(Residence in Baltimore: No. 2837 Bernard St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Sept 4 (Month) (Day), 1894 (Year)

7-AGE, 23 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Gilbert Petticord

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Amanda Imerson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amanda Petticord

(Address) 2837 Bernard St

15- Filed SEP 10 1920 Burial Permit SEP 10 1920 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Louis Morrison M. D.
Coroner

Sept 9, 1920 (Address) 3632 Ridgewood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Sept 11, 1920

20-UNDERTAKER Chenoweth Son — ADDRESS Chestnut Ave

important. See instructions on back of

Spec.—8-24-14—M. & T.—2000 Bks.

1046403 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046403

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 29

CITY OF BALTIMORE: (No. U.S.P.H.S.Hospital #56. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William S. Chase.

(Residence in Baltimore: No. U.S.P.H.S.Hospital #56 Baltimore Md. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single.

6-DATE OF BIRTH, Unknown (Month), (Day), 1 (Year)

7-AGE,	If LESS than 1 day,
20 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert E. Krauter

(Address) U.S.P.H.S. #56 Ft. Henry Balto. Md.

15- SEP 10 1920 ROBERT E KRAUTER
Filed ....., 191.. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 9, 1920. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 13 1920. to Sept. 9 1920.,
that I saw him alive on Sept. 9 1920. 191..,
and that death occurred, on the date stated above, at 10-40 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Miliary Tuberculosis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleurisy Acute fibrinous.

(Duration) yrs. mos. ds.

(Signed) Thomas R. Payne M. D.

Sept. 9, 191... (Address) U.S.P.H.S. #56 Ft. Henry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Unknown.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mechanicsville St Mary's Co Md	Sept 10, 1920.
20-UNDERTAKER	ADDRESS
J Linnor & Bro	1112 E Balto st

Wm H. Bosley.

1... 6-9-19—H. P. Co.—1000 Bks.

1046404 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046404

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 918 E Monument St at

CITY OF BALTIMORE: (No.) 918 E Monument (St.) 10 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Bosley

(a) RESIDENCE. No. 911 Ensor St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. 10 mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	—

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 7-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward J Bosley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Bosley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Edna Jenkins (Address) 1418 E Monument St

15 Filed SEP 10 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9th 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 9 . 1920 . to Sept 9 . 1920 . that I last saw him alive on Sept 9 . 1920 . and that death occurred, on the date stated above, at 9-10 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ... yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary) Weak Heart

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? 911 Ensor St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr E M Kegerreis M. D.

. 19 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Sept 10th 1920
20 UNDERTAKER	ADDRESS
Chas G Bailey	1421 Jefferson St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D46405

D46405

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1527 Mulberry St.; 6 WARD)

2-FULL NAME Mary F. Smith

(r) RESIDENCE. NO. 1527 Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jeremiah Smith

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Peter Kennard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Cremuel Smith 1527 Mulberry St.

15 [illegible] SEP 10 1920 ROBERT E. LEE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1920, to Sept 8, 1920, that I last saw h[illegible] alive on Sept 9, 1920, and that death occurred, on the date stated above, at 3 30 P m.

THE CAUSE OF DEATH* was as follows:

Cerrhosis of Liver.

Mitral Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw. J. Eggerss M. D.

(Address) 1118 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion.

DATE OF BURIAL: Sept 10 1920

20 UNDERTAKER: Edw. Pinggold

ADDRESS: 1463 N Carey St

TION is very important.

Form 6-3-19 H. P. Co.—1000 Bks.

1046406

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046406

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2207 Etting ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Jefferson Warren

(a) RESIDENCE. No. 2207 Etting ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44/5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colred	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Jane Warren

6 DATE OF BIRTH (month, day, and year) Nov 29, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Pa. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Louis Warren

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mary Jane Warren
(Address) 2207 Etting St

15 SEP 10 1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 19 1920, to Sept 8, 1920, that I last saw h~~im~~alive on Sept 7, 1920, and that death occurred, on the date stated above, at 3.50 A. m.

The CAUSE OF DEATH* was as follows:

Vabular Heart Disease

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart 3

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. William Frey, M. D.

Sept 9, 1920 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 12 1920
20 UNDERTAKER	ADDRESS
Edw. Kinggold	1463 N. Carey

Spec.—6-9-19—H. P. Co.—1000 Bks.

046407

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

30 046407

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaiah Murray

(a) RESIDENCE. No. 22 Register St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Levin Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M.T.H.

15 Filed SEP 10 1920 19 ROBERT F. LEATHERS Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1920, to Sept. 7, 1920, that I last saw him alive on Sept. 6, 1920, and that death occurred, on the date stated above, at 6.35 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. D. Fahndrich, M. D.

9-7-20 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Sept 11 19
20 UNDERTAKER Daniel Eagan	ADDRESS 916 Pacific

D46408 HEALTH DEPARTMENT—CITY OF BALTIMORE D46408

64

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1021 N. Carlton St.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Ann Hill

(Residence in Baltimore: No. 1021 N. Carlton ave. St.: 76 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female | 4-COLOR OR RACE: colored | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): widow

6-DATE OF BIRTH, March 4, 1844
(Month) (Day) (Year)

7-AGE, 76 yrs. 6 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook (retired)
(b) General nature of industry, business, or establishment in which employed (or employer): 021

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Sarah Scott.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosetta Hill

(Address) 1021 N. Carlton St.

SEP 10 1920 ROBERT B. KRAUTER

Filed....., 191... Registrar

Burial Permit Issued

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 9, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,

(Duration) ....yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(Duration) ....yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Sept. 9, 1920 (Address) 2812 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn | DATE OF BURIAL, Sept 11, 1920

20-UNDERTAKER Daniel Easton | ADDRESS 116 Penna Ave

D46409 HEALTH DEPARTMENT—CITY OF BALTIMORE D46409

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1235 Mulliken St. ST.; 5 WARD) REGISTERED No. C 28

2-FULL NAME. Maud Pitt

(Residence in Baltimore: No. 1230 Mulliken St.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: (yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept. 8, 1899
(Month) (Day) (Year)

7-AGE, 21 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER, Wm. Jackson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) French Pitt

(Address) 1235 Mulliken St.

15- SEP 10 1920 ROBERT P KRAUTER
Filed ....., 19.. Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 5, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) yrs. mos. 3d ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. C. Fields M. D.
(Coroner.)

1920 (Address) 743 Valley

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Roslyn Va. DATE OF BURIAL Sept 12 20

20-UNDERTAKER, Chas. N. Johnson ADDRESS 406 N. Arch

20.46410 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.46410

CERTIFICATE OF DEATH.

1 PLACE OF DEATH — Registered No. C 84

City of Baltimore (No. Body found in Kirby's Park. St.: 11 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johnnie Richardson.(C)

(Residence in Baltimore: No. 1115 Bolton St.) St.: 1 yrs., ------- mos. ------- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female.	Colored.	Married.

6-DATE OF BIRTH. ..... Do not know. (Month), ... (Day), 1 (Year)

7-AGE.	If LESS than 1 day,
21 yrs. ---------- mos. ---------- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). North Carolina.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nannie Henderson.(C)

(Address) 1115 Bolton St.

15- SEP 10 1920 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Missing Aug. 29. 1920 ...Body found September 4, 1920, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... " over " .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Hobt C Remsard M. D. (Coroner)

Sep. 9th, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. PUBLIC CEMETERY.

DATE OF BURIAL, ..., 19....

20-UNDERTAKER

ADDRESS SEP 10 1920

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

10.46411 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.46411

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3402 Clifton ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Clara Metz

(a) RESIDENCE. No. 3402 Clifton ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. 2 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles M. Metz

6 DATE OF BIRTH (month, day, and year): July 4. 1856

7 AGE — Years: 64 Months: 2 Days: 5 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: Your

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thos. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Margaret Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Chas M Metz
(Address) 3402 Clifton Ave

15 Filed ....., 19.... Robert P. Harrison, Registrar

EP 10 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1920 to Sept 9, 1920 that I last saw h[illegible] alive on Sept 9, 1920 and that death occurred, on the date stated above, at 2 03 80 m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? 3402 Clifton Ave

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) [illegible] M. D.

9/10 1920 (Address) 814 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Sept 11 1920
20 UNDERTAKER	ADDRESS
H. J. Tschudy Sons	North Ave

CAUSES OF DEATH. See instructions on back of certificate. TION is very important.

20.46412 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.46412

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore

CITY OF BALTIMORE (No. General Hospital. St.: 24 WARD) 186

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest D. Frome.

(Residence in Baltimore: No. 1741 Belt St. St.; yrs. 54 mos. 6 ds. 13)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, February 26th, 1866, 1
(Month) (Day) (Year)

7-AGE, 54 yrs. 6 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sawyer.
(b) General nature of industry, business, or establishment in which employed (or employer): Picture frame Factory.

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Christian Frome.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Elizabeth Cook.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elmer Frome. (son)

(Address) 1741 Belt St.

15-
Filed SEP 10 1920, 191
Registrar.
~~Burial Permit Clerk.~~

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 8th. 1920, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Injuries, accidentally struck in abdomen by a Board. (Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary) ... (Duration) ...yrs...mos...ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

Sept. 10th, 20. 191... (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs...mos...ds. In the State ...yrs...mos...ds.

Where was disease contracted, if not at place of death? Hurst Bros. & Co. Race & Ostend Sts.

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, London Park Cem. DATE OF BURIAL, Sept. 11, 1920

20-UNDERTAKER Margaret D. Flynn ADDRESS 1422 Light St.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.46413

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46413

CERTIFICATE OF DEATH.

104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.: 10 WARD)

2-FULL NAME Adrian Blum.

(a) RESIDENCE. NO. 727 Greenmount Ave. ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 21 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. dd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob A. Blum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Ruth Lancaster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Record
(Address) J. H. H.

15 Filed SEP 10 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 4, 1920, to Sept. 9, 1920, that I last saw him alive on Sept. 9, 1920, and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. C. Davison M. D.

. 19 (Address) Johns Hopkins Hosp. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Sept. 11 1920

20 UNDERTAKER H. E. Hughes ADDRESS 1715 Bolton

Dec.—6-9-19—H. P. Co.—1000 Bks.

D.46414 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46414

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 Hillen St 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Laughlin

(a) RESIDENCE. NO. 827 Hillen ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of Richard Laughlin

6 DATE OF BIRTH (month, day and year) Oct 21 1846

7 AGE: Years 74 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Boyle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: John C Barrett (Address): 827 S Hillen St

15 Filed SEP 10 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1920, to Sept 10, 1920, that I last saw her alive on Sept 10, 1920, and that death occurred, on the date stated above, at 5 30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Hornstein, M. D.

9/10, 1920 (Address) 733 Arquith st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lyons-Loy Co | DATE OF BURIAL: 9/13 1920

20 UNDERTAKER: W. H. Lach | ADDRESS: 532 E Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46415 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46415

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1740 Johnson ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan E Riggin

(a) RESIDENCE. NO. 1740 Johnson ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apl 19/20

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

600

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Jas A Riggin

11 BIRTHPLACE OF FATHER (city or town) Balto Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Stella Walter

13 BIRTHPLACE OF MOTHER (city or town) Balto Co
(State or country) Md

14 Informant Jas A. Riggin
(Address) 1740 Johnson st

15 Filed SEP 10 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

THIS IS VERY Important

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to Sept 10, 1920 that I last saw h alive on Sept 9, 1920 and that death occurred, on the date stated above, at 6-30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H E R Campbell M. D.

Sept 10. 1920 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Sept 11 1920
20 UNDERTAKER	ADDRESS
John F Denny.	715 Light St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46416 HEALTH DEPARTMENT—CITY OF BALTIMORE D/46416

CERTIFICATE OF DEATH. 104-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3711 Benefit St. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred May Weddle

(a) RESIDENCE. NO. 3711 Benefit ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 28-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Vernon Weddle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Kennick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Vernon Weddle

Address 3711 Benefit St

Filed SEP 11 1920, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1920, to Sept 10, 1920

that I last saw h 11 alive on Sept 10, 1920,

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows: Acute Lobar Pneumonia.

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia.

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. F. Hanahan, M. D.

Sept 11, 1920 (Address) 3505 Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Sept 11 1920
20 UNDERTAKER John J. Gerwig & Co	ADDRESS 2008 Eutaw

Spec.—6-9-19—H. P. Co.—10M0 Bks.

D.46417 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46417

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1137 Harford ave ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. David C. Erdman

(a) RESIDENCE. NO. 1137 Harford ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 3 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Eliza J Erdman

6 DATE OF BIRTH (month, day, and year) May 27th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brass Moulder 010

(b) General nature of industry, business, or establishment in which employed (or employer) Poole Engineer Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frederick Erdman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Susanna Deal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Eliza J Erdman

(Address) 1137 Harford ave

15 Filed SEP 11 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9th 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1 19-0, to Sept 9 19-0, that I last saw him alive on Sept 9 19-0, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo E Young M. D.

19 (Address) 1167 Lexington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept 13th 1920
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

D.46418 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46418

CERTIFICATE OF DEATH.

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE (No 98-3rd. Ave Wagner's Point ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Anna Bialecka.

(Residence in Baltimore: No. 98-3rd. Ave. Wagner's Point. St.: yrs. 10 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Single.

6-DATE OF BIRTH. October 25th. 1919, (Month) (Day) / (Year)

7-AGE. ..... yrs. 10 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Bolislaw Bialecka.

11-BIRTHPLACE OF FATHER (State or Country). Poland.

12-MAIDEN NAME OF MOTHER. Stanilawa Czwesnka.

13-BIRTHPLACE OF MOTHER (State or Country). Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bolislaw Bialecka(father)

(Address) 98-3rd. Ave. Wagner's Point.

15-

Filed SEP 11 1920, 191.....

Registrar.

Robert P. Harrison,
Burial Permit Clerk.

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 10th. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

Sep. 10, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Holy Cross DATE OF BURIAL: Sept 11, 1920

20-UNDERTAKER: Wm Hallowell ADDRESS: 1816

D.46419 HEALTH DEPARTMENT--CITY OF BALTIMORE D.46419

CERTIFICATE OF DEATH 104-091

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2218 Fleet St. 1 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Marzianna Tylus

(Residence in Baltimore: No. 2218 Fleet St

St.: - yrs. 11 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: September (Month) 21 (Day) 1919 (Year)

7 AGE: yrs. 11 mos. 20 ds. If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Mathew Tylus

11 BIRTHPLACE OF FATHER (State or country): Poland

12 MAIDEN NAME OF MOTHER: Antonina Kufera

13 BIRTHPLACE OF MOTHER (State or country): Poland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mathew Tylus

(Address) 2218 Fleet St

15 Filed SEP 11 1920, 191

Robert P. Harrison,
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: September (Month) 10 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1920, to Sept 10 1920, that I saw her alive on Sept. 10, 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) yrs. 2 mos. — ds

Contributory (SECONDARY) Bronchio-Pneumonia

(Duration) yrs. — mos. 8 ds.

(Signed) Morris Abramowitz M. D.

Sept 10, 1920 (Address) 1707 E. Bills st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Rosary — DATE OF BURIAL: September 11 1920

20 UNDERTAKER: John P. Weber — ADDRESS: 1803 Bank St

*State CAUSE OF DEATH in plain terms. Indefinite or unsatisfactory answers are not sufficient. See instructions on back of certificate. This is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 46420

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 46420

CERTIFICATE OF DEATH.

104

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1703 Druid Hill Av ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Harvey Conrad Griggs

(Residence in Baltimore: No. 1703 Druid Hill Av St.; ....yrs., ...mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, May (Month) 19 (Day), 1919 (Year)

7-AGE, 1 yrs. 4 mos. 30 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Wm. B. Griggs.

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Ethel Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ethel Griggs

(Address) 1703 Druid Hill Ave

SEP 11 1920 Filed....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 8th (Day), 1920 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 2 1920, to Sept 7 1920, that I saw him alive on Sept 7th 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(Duration) ....yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 6 ds.

(Signed) J. W. Hughes M. D.

Sept 8, 1920 (Address) 1443 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Sept 11, 1920

20-UNDERTAKER Samuel Lemmey ADDRESS 5 E Biddle St

Spec.—8-24-14—M. & T.—2000 Blks.

D. 46421

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 46421

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 14 WARD)

REGISTERED NO. C 1201

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Denny.

(Residence in Baltimore: No. 539 Presstman st ... Ward. ... yrs. ... mos. ... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... Unknown ....., 1862
(Month) (Day) (Year)

7-AGE, 58 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Aaron Mosall

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eliza Bowers

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. P. Denny

(Address) 539 Presstman St

15-

SEP 11 1920 Filed ..... 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 10th 1920, to Sept 8th 1920, that I saw her alive on Sept 7th 1920, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) 1 yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary) Not known

(Duration) ... yrs. ... mos. ... ds.

(Signed) Harry J. Bryan M. D.

Sept 8, 1920 (Address) 541 Presstman st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. 1 mos. 5 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 539 Presstman st.

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Sept 11 1920

20-UNDERTAKER Samuel Kemsley — ADDRESS 1 E Biddle

Spec.—8-24-14—M. & T.—2000 Bks.

0.46422 HEALTH DEPARTMENT—CITY OF BALTIMORE 046422

CERTIFICATE OF DEATH.

REGISTERED No. C 6

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 Lancaster ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Archer

(Residence in Baltimore: No. 1711 Lancaster St.; 1 yrs., 11 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	

6-DATE OF BIRTH, April 2, 1919
(Month) (Day) (Year)

7-AGE, 1 yrs. 5 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John H Archer

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Anna Phipps

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Archer

(Address) 1711 Lancaster St

15- SEP 11 1920 Robert F. Harrison, Burial Permit Clerk.

Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 10, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 9 1920, to Sept. 10 1920, that I saw her alive on Sept 9 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Measles

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) yrs. mos. 1 ds.

(Signed) John H. Kelbersyer M. D.

Sept. 10, 1920. (Address) 1709 Fleet Anne St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel Cemetery	Sept 11, 1920.
20-UNDERTAKER	**ADDRESS**
H. Sander & Son	17th Fleet St

Important. Be sure to fill out all items.

D.46423

HEALTH DEPARTMENT—CITY OF BALTIMORE D46423

CERTIFICATE OF DEATH.

104

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 524 Dwight ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Langerber

(Residence in Baltimore: No. 524 Dwight St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, white | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May 16, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. 27 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John D Langerber

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Sidney Cook

13-BIRTHPLACE OF MOTHER (State or Country), New

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Sidney Langerber

(Address) 524 Dwight

15-

Filed ....., 191....

Registrar.

SEP 11 1920

Robert P. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 10, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Henry A. Duncan M. D.
(Coroner.)

Sept 10 1920 (Address) 1807 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trinity Cem. | DATE OF BURIAL, Sept 11th 1920

20-UNDERTAKER D. Sander & Sons | ADDRESS 1710 East St.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

10.46424 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.46424

CERTIFICATE OF DEATH.

28 V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2418 Fait Ave ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles D. Bauer

(a) RESIDENCE. No. 2418 Fait Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pearl Bauer

6 DATE OF BIRTH (month, day, and year) June 8, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cutter 086

(b) General nature of industry, business, or establishment in which employed (or employer) Shirt

(c) Name of employer Jacob. Bros. Balto

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Bauer

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Schweder

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Pearl Bauer (Address) 2418 Fait Ave

15 Filed SEP 11 1920 19 Robert F. Harr... Registrar

Burial Permit Clerk in Ch...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1920

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1920, to Sept 10, 1920

that I last saw her alive on Sept 10, 1920

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary 1 2

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Theo Koerner, M. D.

Sept 11 1920 (Address) 34 So Durham Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Cemetery	Sept 13 1920
20 UNDERTAKER	ADDRESS
H. Sander Sons	1210 Fleet

TION is very important. See instructions

Dr Goldenberg 34

Spec.—6-9-19—H. P. Co.—100(Bks.

D.46425 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46425

42

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 St Paul St ST.; 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. A. Dent Hull

(a) RESIDENCE. No. 916 St Paul ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~ (write the word): Widow

5a If married, widowed, ~~or divorced~~
~~HUSBAND~~ of (or) WIFE of Thomas G. Hull

6 DATE OF BIRTH (month, day, and year) January 30-1849

7 AGE: Years 71 Months 7 Days 10 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady, at Home

(b) General nature of industry, business, or establishment in which employed (or employer) Home.

(c) Name of employer

9 BIRTHPLACE (city or town) Washington
(State or country) DC

PARENTS

10 NAME OF FATHER Henry Nalle Dent

11 BIRTHPLACE OF FATHER (city or town) Charles Co
(State or country) md.

12 MAIDEN NAME OF MOTHER Anne Maria Adams

13 BIRTHPLACE OF MOTHER (city or town) Anne De Grael
(State or country) md.

14 Informant Andrew W. Hull
(Address) 916 St Paul St.

15 Filed SEP 11 1920, 19.... Robert F. Harrison
Registrar
(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1920

17 I HEREBY CERTIFY, That I attended deceased from July, 1919, to Sept 10, 1920, that I last saw her alive on Sept 10, 1920, and that death occurred, on the date stated above, at 1.30 p m.

The CAUSE OF DEATH* was as follows:

Cardiac embolism

Instantaneous.
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cancer uteris. (Body)
(duration) ....yrs. 10 mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Uterine scrapings

(Signed) J. Warren Bruckner, M. D.

, 19 (Address) 806 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brookland Pa — DATE OF BURIAL: Sept 12 1920

20 UNDERTAKER: Emory W. Hutchins Undertaking Co — ADDRESS: Baltimore Md

THIS IS VERY IMPORTANT

Spec.—8-24-14—M. & T.—2000 Bks.

D. 46426

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 46426

CERTIFICATE OF DEATH.

45V

REGISTERED NO. C.....

1-PLACE OF DEATH Maryland

CITY OF BALTIMORE: (Union Memorial Hosp. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Thompson

(Residence in Baltimore: No. 2015 Boston St.; 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Color

5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH. June (Month) 12 (Day) 1851 (Year)

7-AGE. 69 yrs. 2 mos. 28 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or Country) Maryland.

PARENTS.

10-NAME OF FATHER. W. S. Thompson

11-BIRTHPLACE OF FATHER (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER. Mary E. Broome

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. A. Thompson

(Address) M. M. H.

15-

Filed ....., 191.....

Registrar.

SEP 11 1920

Robert P. Harrison
Burial Permit Clerk

Important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 10 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7 1920, to Sept 10 1920, that I saw him alive on Sept 9 1920 and that death occurred, on the date stated above, at 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Hypernephroma

..... (Duration) ..... yrs. ..... mos. ..... ds.

Metastasis to spine & lung

CONTRIBUTORY (Secondary) about one mo.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Hammerbacher M. D.

Sept. ....., 1920. (Address) U. M. H.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 27 ds. In the State 69 yrs. 2 mos. 28 ds.

Where was disease contracted, if not at place of death? In Balto. City

Former or usual residence 2015 Boston St. Balto.

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge Cem. DATE OF BURIAL: 9—13.. 1920

20-UNDERTAKER: Henry W. Jenkins & Son Co. ADDRESS: Orchard & McCulloh

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Roehner)

D 46427

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46427

CERTIFICATE OF DEATH.

1152

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Agnes' Hospital ST.: WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Rochner

(a) RESIDENCE. NO. 1922 N. Mulberry St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): May 8 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Musician 086

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): St Dennis Balto Co. Md.

PARENTS

10 NAME OF FATHER: Fred'k Scales

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Mary Judd.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. Africa

14 Informant: Mrs. Scales

(Address) 1942 N. Mulberry St.

15 Filed SEP 11 1920 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-10 1920

17 I HEREBY CERTIFY, That I attended deceased from 9-7, 1920, to 9-10, 1920, that I last saw her alive on 9-10, 1920, and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Catarrhal jaundice

3 weeks

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/10/20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. M. K. Craig, M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Edward Clark

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 13 1920

20 UNDERTAKER: Geo. A. Herbig ADDRESS 2001 W. Baltimore St

THIS IS VERY IMPORTANT.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46428

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46428

CERTIFICATE OF DEATH.

692

1-PLACE OF DEATH Hebrew Home of Incurables

REGISTERED NO.

CITY OF BALTIMORE: (No. 2102 E. Balto. ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Kaufberg

(a) RESIDENCE. NO. 208 W. Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
fm.	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Katzenberg

6 DATE OF BIRTH (month, day, and year) October 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Shoe Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Alexander Katzenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Swartz

(Address) 305 N. Lexington St.

15 Filed SEP 11 1920 16 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 31, 1920, to Sept. 8, 1920, that I last saw h... alive on Sept. 8, 1920, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Epilepsy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S. G. Nicholson, M. D.

, 19 (Address) 1420 E. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew Cem	9/11 1920
20 UNDERTAKER J. Abrens Co	ADDRESS 16 N. Eutaw

TION is very important. See reverse

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 46429

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 46429

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.: 7 WARD)

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E Rankin

(a) RESIDENCE. No. Louisville Ky. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emily Rankin

6 DATE OF BIRTH (month, day, and year) April 3-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54		5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R R Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER John E Rankin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Mary Sprowl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Hospital Record (Address) J. H. H.

15 Filed SEPT 11 1920

16 Robert P. Harrison Registrar

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11- 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 25- 1920 to Sept 11 1920, that I last saw him alive on Sept 11 1920, and that death occurred, on the date stated above, at 345 a m.

The CAUSE OF DEATH* was as follows:

Arteria-Sclerosis - Chronic nephritis
Chronic myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry M. Thomas Jr., M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL White Haven Pa

DATE OF BURIAL Sept 11 1920

20 UNDERTAKER Joseph Ahrens

ADDRESS 221 N Bway

Burial Permit Clerk.

Spec.—8-24-14—M. & T.—2000 Bks.

D.46430 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46430

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 324 E. 28th St. ST.; 12 WARD)

REGISTERED NO. C 289

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter H. Watson

(Residence in Baltimore: No. 324 E. 28th St. St.; 25 yrs. 1 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.)
Male	White	Single

6-DATE OF BIRTH, June 23, 1895 (Month) (Day) (Year)

7-AGE, 25 yrs. 1 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Soldier U.S.A. Retired
(b) General nature of industry, business, or establishment in which employed (or employer): U.S.

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Walter H. Watson

11-BIRTHPLACE OF FATHER (State or Country), West Va.

12-MAIDEN NAME OF MOTHER Emma J. Carr

13-BIRTHPLACE OF MOTHER (State or Country), Norfolk Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter H. Watson

(Address) 324 E. 28th St.

15- Robert P. Harrison,

Filed ..... 20 ..... 191 ..... Registrar.

Burial Permit Cl...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 10, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 191 9, to Sept 10 1920, that I saw him alive on Sept 9. 1920, and that death occurred, on the date stated above, at 12.1 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) almost 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage Cerebellum

(Duration) 1 yrs. mos. ds.

(Signed) Charles D. Moran M. D.

Sept 10, 1920 (Address) 5 E. Read St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Sept. 13., 1920
20-UNDERTAKER	ADDRESS
Mrs. Mrs. John W. Siepel	801 N. Fayette

important. See instructions on...

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.46431 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46431

CERTIFICATE OF DEATH. 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hosp. ST.: 7 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Barbara Novak.

(a) RESIDENCE. No. 2036 Ashland Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Novak.

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General natore of Industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Jo. Achraiccia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not Known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant John Novak

(Address) 2036 Ashland Ave

15 Filed ..... 19..... Robert P. Harrison, Registrar

SEP 2 1920 Burial Permit Clerk

TION is very important. See instructions on back of c

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-1 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 25, 1920, to Sept. 1, 1920, that I last saw her alive on Sept. 8, 1920, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Epigastric Hernia

(duration) 16 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism 20 Min

(duration) ..... yrs. ..... mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 27, 1920

Was there an autopsy? No

What lest confirmed diagnosis?

(Signed) F. A. Holden, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	Sept 12 1920
20 UNDERTAKER Hunt & Eveck & Son	ADDRESS 1900 Eastland

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46432

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46432

150

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 151 Belvedere Ave WARD 27)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Hare

(a) RESIDENCE. No. 151 Belvedere Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, 5 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm L Hare

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Blanche L Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm L Hare
(Address) 151 Belvedere Ave

15 Filed SEP 11 1920 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-10 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1920, to Sept 10, 1920, that I last saw him alive on Sept 10, 1920, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Valvular Heart Disease. 4 hours.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 8 mos Pregnancy.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) W. R. Coplen M. D.

. 19 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Sept 11 1920

20 UNDERTAKER Paul E Chenoweth ADDRESS 3617 Chestnut Ave

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

246433 HEALTH DEPARTMENT—CITY OF BALTIMORE D.246433

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.: 12 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Carter Roddey

(a) RESIDENCE. NO. 326 Worsley St. Worsley Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? ? 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42 yrs	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dr Larew

9 BIRTHPLACE (city or town) (State or country) Bath Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Louisa Roddey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Ethelin Carter
(Address) 738 Lemmon Street

15 Filed SEP 11 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-10 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1920, to Sept 10, 1920, that I last saw him alive on Sept 10, 1920, and that death occurred, on the date stated above, at 6:10 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus (Coma)

(duration) - yrs. 3 mos. - ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? - Date of -

Was there an autopsy? -

What test confirmed diagnosis?

(Signed) W. G. Geyer, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Odd Fellows Cemetary	Sept 11th 1920
20 UNDERTAKER	ADDRESS
Samuel Wm Smith	364 Pacific

Mad 4464

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 46434

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46434

CERTIFICATE OF DEATH.

104

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1701 Ruxton ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Bacharach

(a) RESIDENCE. No. 1701 Ruxton ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) Oct 29-1919

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER David N. Bacharach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Irene E. Winternitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant David N. Bacharach
(Address) 1701 Ruxton ave

15 Filed Robert P. Harrison, Registrar
SEP 11 1920 [Burial Permit Clerk.]

TION is very important. See instruction

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 1920

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1920, to Sept 10, 1920, that I last saw him alive on Sept. 10, 1920, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Decomposition Intestinal

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease

(duration) yrs. 10 mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. Loring Joslin, M. D.

. 19 (Address) 35 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew	9-12-20
20 UNDERTAKER David Sandheim	ADDRESS 118-20 W Mt Royal Ave

46435 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 46435

CERTIFICATE OF DEATH.

4 + 174

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mmersity Hospital St. 4 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emaurl C. Forney

(Residence in Baltimore: No. Silver Run Carroll Co Md St.: yrs., — mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Marr'd

6-DATE OF BIRTH, Aug 7th, 1852.
(Month) (Day) (Year)

7-AGE, 67 yrs. 11 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Ret'd

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Emaurl Forney

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary C Fraser

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emaurl Forney Jr.

(Address) 1717-N. Register St.

15-SEP 12 1920 ROBERT P KRAUTER
Filed....., 191.....
Burial Permit Register

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 9, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Contusion Fracture Rt Radius & Ulna & Clavicle Influenza

(Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Accident, arm caught in corn husking machine

(Duration) ..... yrs. ..... mos. 12 ds.

(Signed) H. R. Gorsuch, M. D.
(Coroner)

9-10-, 1920 (Address) 117 W. Pleasant

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Silver Run Md.

19-PLACE OF BURIAL OR REMOVAL Md Silver Run, Carroll Co — DATE OF BURIAL, 9/17/20 19....

20-UNDERTAKER George J. Putt — ADDRESS 1735-Hanford Ave

CAUSE OF DEATH should be stated by the physician if possible. Every question should be answered if information can be obtained. Typewriting or printing is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

046436

HEALTH DEPARTMENT—CITY OF BALTIMORE

046436

CERTIFICATE OF DEATH.

15 V

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 8 S. Castle ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Beran

(a) RESIDENCE. NO. 8 S. Castle ST. 6 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 15/20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Herman Beran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliz. Stacke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Benjamin Beran
(Address) 8 S Castle St.

15 Filed SEP 12 1920, 19.. ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 19 20.

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 19 20, to Sept 11, 19 20,
that I last saw h..... alive on Dec Sept 11, 19 20,
and that death occurred, on the date stated above, at ? m.
The CAUSE OF DEATH* was as follows:

Prolonged Labor.

Breech Extraction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. L. Meyer Jr. M. D.

9/12, 1920 (Address) 1738 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	9/13/20
20 UNDERTAKER	ADDRESS
Wendell Dippel Son	378 Conn

TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

046437

HEALTH DEPARTMENT—CITY OF BALTIMORE

88 046437

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital St. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernice O'Connell

(a) RESIDENCE. NO. 9 Belvidere Terrace ST., Mt. Washington WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single.

6 DATE OF BIRTH (month, day, and year): Aug 31 1900

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
20	—	10	

6 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: nothing

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Penna

PARENTS

10 NAME OF FATHER: Thomas O'Connell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna.

12 MAIDEN NAME OF MOTHER: Florence Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: Thomas O'Connell (Address) 9 Belvedere Terrace

15 Filed SEP 12 1920 19 ROBERT B. BAUTER Registrar Burial Permit Clerk

TION is very important. Se[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1920, to Sept 10, 1920, that I last saw h.r. alive on Sept 10, 1920, and that death occurred, on the date stated above, at 11.00 a.m.

The CAUSE OF DEATH* was as follows:

Acute Hyperthroidism

(duration) yrs. 6 mos. 2 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 6 mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? yes Date of Sept 10, 20

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard P. McEwan, M. D.

19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept 11 1920
20 UNDERTAKER: Josiah Lyser	ADDRESS: 1600 N. Howard St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046438 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046438

CERTIFICATE OF DEATH. X91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 East ST.: 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Calvin Plifer

(a) RESIDENCE. No. 212 East ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 19/1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond
(State or country) Va

PARENTS

10 NAME OF FATHER Hayden Plifer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Julia Norman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Rose Brown
(Address) 213 East St.

15 Filed SEP 12 1920 ROBERT F. ELDER Registrar
Burial Permit Clerk

TION is very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1920, to Sept. 9, 1920, that I last saw him alive on Sept. 9, 1920, and that death occurred, on the date stated above, at 4-45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J. Green, M. D.

9-11, 1920 (Address) 130½ Ausquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Sept 12 1920
20 UNDERTAKER	ADDRESS
Mrs Joseph Locke	1302 Pe

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46439 HEALTH DEPARTMENT—CITY OF BALTIMORE D46439

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 W. Franklin ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles N. Gunnstein

(a) RESIDENCE. No. 1511 W. Franklin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wht.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Stocksdale

6 DATE OF BIRTH (month, day, and year) Jany 9th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet maker 614

(b) General nature of industry, business, or establishment in which employed (or employer) Gen. Fact.

(c) Name of employer Furniture Co.

9 BIRTHPLACE (city or town) Frederick Md.
(State or country)

PARENTS

10 NAME OF FATHER Fred. Gunnstein

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Spangler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Emma Gunnstein
(Address) 1511 W. Franklin St.

15 Filed ..19.. ROBERT N. KRAUTER Registrar
SEP 12 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept ..19.. 18 to Sept 11 ..19.. 20, that I last saw him alive on Sept. 10 ..19.. 20, and that death occurred, on the date stated above, at 5.45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
& High Blood Pressure

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cong. of Brain

(duration) yrs. mes. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood pressure & urinalysis

(Signed) E. A. Smith, M. D.

(Address) 1600 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 15 192[illegible]
20 UNDERTAKER George J. Smith	ADDRESS 1000 W Fayette

TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

1946440

HEALTH DEPARTMENT—CITY OF BALTIMORE

1946440

43

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. St.: 27 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Fannie Waters

(a) RESIDENCE. No. Mount Washington St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Waters

6 DATE OF BIRTH (month, day, and year) Feb 10 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Morris Weinberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Jennie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edward Walters

(Address) 1509 W. Baltimore st

15 Filed SEP 12 1920 19 ROBERT P. CHANTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1920, to Sept 11, 1920

that I last saw her alive on Sept 11, 1920

and that death occurred, on the date stated above, at 8 o'clock a m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Breast)

(duration) last summer. yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis (Interstitial)

(duration) last summer. yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No Date of —

Was there an autopsy? Yes. Yes.

What test confirmed diagnosis? Clinical

(Signed) G. J. Gillis, M. D

. 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Sept 14 1920
20 UNDERTAKER	ADDRESS
George J. Smith	1000 W. Fayette st

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0946441

HEALTH DEPARTMENT—CITY OF BALTIMORE

0946441

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1128 W Saratoga ST.: 18 WARD)

2-FULL NAME Richard L Fortune Sr.

(a) RESIDENCE. NO. 1128 W Saratoga ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. 4 mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy J Fortune

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 640

(b) General nature of industry, business, or establishment in which employed (or employer) Concrete

(c) Name of employer Essex G. Co

9 BIRTHPLACE (city or town) (State or country) Essex G. Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant R L Fortune Jr.
(Address) 111 S W Saratoga

15 Filed SEP 12 1920 ROBERT B CRAWFORD Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1920, to Sept 8, 1920, that I last saw h..... alive on Sept 8, 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

. 19 (Address) 439 N Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
E Lawn	Sept 12 1920

20 UNDERTAKER Edw Ringgold 402 Cary ADDRESS

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

1046442

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046442.

CERTIFICATE OF DEATH.

REGISTERED No. C 19

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 Hanover ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. A. Story

(Residence in Baltimore: No. 1007 Hanover St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Feb 28, 1861
(Month) (Day) (Year)

7-AGE. 59 yrs. 6 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mariner
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Ind

PARENTS.

10-NAME OF FATHER, John E. Storey

11-BIRTHPLACE OF FATHER (State or Country), Ind

12-MAIDEN NAME OF MOTHER Henrietta Pickfield

13-BIRTHPLACE OF MOTHER (State or Country), Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian M. Storey

(Address) 1007 Hanover St

15- SEP 12 1920 ROBERT B KRAUTER

Filed ....., 191. Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 10, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 3 1920, to Sept 10 1920, that I saw him alive on Sept 10 1920, and that death occurred, on the date stated above, at 8 0 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(Duration) yrs. mos. 5 ds.

(Signed) Hubert C Blake M. D.

Sept 11, 1920. (Address) 1014 S. 4th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Centerville Ind	Sept 13, 1920.
20-UNDERTAKER	ADDRESS
E Schloman & Son	1031 Hanover St

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046443

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046443

CERTIFICATE OF DEATH.

1109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4818 Delevare Ave ST. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Schwartz

(a) RESIDENCE. NO. 4818 Delevare Av ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? 77 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Schwartz

6 DATE OF BIRTH (month, day, and year): June 16/39

7 AGE	Years	Months	Days	If LESS than 1 day,... hrs. or ... min.
	81	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): 500

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Henry Hampfield

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Harry E. Schwartz

(Address) 4818 Delevare Av

15 Filed ... 19... SEP 12 1920 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 5- 1920, to Sept 10 1920, that I last saw h[illegible] alive on Sept 9 1920, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) mos. ds.

CONTRIBUTORY (Secondary) Substitute Nurse

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical symptoms

(Signed) C B Lemmon, M. D.

(Address) 718 N Patterson Pk —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cem.	Sept 13 20

20 UNDERTAKER: Philip Herwig ADDRESS 2016 Orleans

CAUSE OF DEATH must be filled in plainly. See instructions on back of certificate. TION is very important.

Spec. 6-3-19—H. P. Co.—1000 Blks.

D46444 HEALTH DEPARTMENT—CITY OF BALTIMORE D46444

CERTIFICATE OF DEATH. 42

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2933 Guilford Ave 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma V. Hohlbein

(a) RESIDENCE No. 2933 Guilford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs 9 mos 12 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28/79

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Frederick Hohlbein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Thos. H. Champness
(Address) 2933 Guilford

15 Filed SEP 12 1920 19 ROBERT E. KRAEMER Registrar
Burial Permit Clerk

TION is very important. See instructions on BACK

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) Sept 10 1920

17 I HEREBY CERTIFY, That I attended deceased from May 15th, 1920, to Sept. 10th, 1920, that I last saw her alive on Sept. 10th, 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(duration) — yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) (duration) * yrs. * mos. * ds.

18 Where was disease contracted * * * *
If not at place of death?

Did an operation precede death? yes Date of Feb. 25/20

Was there an autopsy? no

What test confirmed diagnosis? microscopical examination

(Signed) Edw. M. Dingwall, M. D.

9/11, 1920 (Address) 5 N. Washington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Sept 13 1920
20 UNDERTAKER Philip Hennig	ADDRESS 2016 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046445 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046445

CERTIFICATE OF DEATH. 105

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 709 N. Linwood Ave. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME F. Albert Haase Jr.

(a) RESIDENCE. No. 709 N. Linwood Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 9 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 12/16

7 AGE — Years: 3 Months: 9 Days: 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER F. Albert Haase Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. O'Neil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant F. Albert Haase Sr.

(Address) 709 N. Linwood

15 Filed SEP 12 1920 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1920, to Sept 10, 1920, that I last saw him alive on Sept 10, 1920, and that death occurred, on the date stated above, at 11 50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Ulcerative Colitis

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Findings

(Signed) M Murphy M. D.

(Address) 5002 Dellcrest Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Sept 13 1920

20 UNDERTAKER: Philip Herwig — ADDRESS: 2016 Orleans

CAUSE OF DEATH to plainly written or typewritten. See instructions on back of certificates. TION is very important.

1046446 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046446

CERTIFICATE OF DEATH.

166

REGISTERED No. C.

1-PLACE OF DEATH Baltimore Dry Docks & Ship

CITY OF BALTIMORE (No. Building Co. South Plant. ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William C. Weber.

(Residence in Baltimore: No. 806 S. 7th, St. Highlandtown, St.: 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, March 3rd, 1857, 1 (Month) (Day) (Year)

7-AGE, 63 yrs. 6 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carperter in
(b) General nature of industry, business, or establishment in which employed (or employer): Ship yard.

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, John Weber.

11-BIRTHPLACE OF FATHER (State or Country), Germary.

12-MAIDEN NAME OF MOTHER Rose Meyer.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Weber. (wife).

(Address) 806 S 7th St. Highlandtown

15- FILED SEP 12 1920 191 ROBERT B. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 10th, 1920, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns about face & body
Accidentally burned in a fire in refrigerator room on S.S. Aeolus.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto R. Reinhardt M. D. (Coroner.)

Sept. 12th, 1920 (Address) 1017 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Mathews Cemetery	Sept. 13., 19....
20-UNDERTAKER	**ADDRESS**
Louis Heeman	928 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

046447. HEALTH DEPARTMENT—CITY OF BALTIMORE 046447

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Baltimore Md ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Levin

(Residence in Baltimore: No. 141 N. Exeter St St.; ~~60~~ yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, January 1 (Month) (Day) (Year)

7-AGE, 6 yrs. mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Pants 8°
(b) General nature of industry, business, or establishment in which employed (or employer) Pressers

9-BIRTHPLACE, (State or Country), Russia

PARENTS

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jake Levin

(Address) 1411 E Baltimore St

15- Filed SEP 14 1920 ROBERT B KRAUTER Registrar. 191.....

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 17, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 2, 1920, to September 17 1920, that I saw h im alive on September 12, 1920, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Hypernephroma

with metastases

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma

(Duration) yrs. mos. 7 ds.

(Signed) Charles S. Levy M. D.

9-17-20, 191... (Address) Mt. Sinai Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 10 ds. In the State 20 yrs. mos. ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 141 N. Exeter St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mt Carmel — DATE OF BURIAL, 9-17-, 1920

20-UNDERTAKER Jack Levin — ADDRESS 1411 E Baltimore

CAUSE OF DEATH must be stated in plain terms. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Wilmer Brinton

D. 46448

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 Calmert Street

79 V 046448

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 N. Bond St. ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Clark

(a) RESIDENCE. No. 1514 N. Bond ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. F. Clark

6 DATE OF BIRTH (month, day, and year) Feb. 10 1848

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
72	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Frisch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Sophia Frida Sept 10 1848

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe

14 Informant Mrs L. Gellein
(Address) 1606 E Federal

15 Filed SEP 12 1920 ROBERT P. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1920

17 I HEREBY CERTIFY, That I attended deceased from ....., 19.20., to May 1st, 19.20., that I last saw h.r alive on May 8th, 19.20., and that death occurred, on the date stated above, at 5 p.m. m.

The CAUSE OF DEATH* was as follows:

Senile Heart with Fatty degeneration.

Many Years (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Died Suddenly

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Consultations.

(Signed) Wilmer Brinton, M. D.

Sept 10 1920 (Address) Dr. S.W. Cor. Calmert & Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park.	Sept 13 1920
20 UNDERTAKER Wm Cook	ADDRESS 5 N Gilmor.

CAUSE OF DEATH ... TION is very important. See instructions on ... s on back of certificate.

Off Gr. L. 93 Ladies M. to Inter at Leisure

1046449 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046449

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital ST.) 2 WARD) 175-001 REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred Trueszinski

(Residence in Baltimore: No. 806 S. Ann. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Single

6-DATE OF BIRTH, July (Month) 26 (Day) 1905 (Year)

7-AGE, 15 yrs. 1 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer): Roland Bro

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Paul Truszkowski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Bessie Kulinski

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Paul Truszkowski
(Address) 806 S Ann St

15- Filed SEP 12 1920, 191.... ROBERT B KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 10 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractur of Skull.
Accident
(Duration) yrs. mos. 3 hs
CONTRIBUTORY (Secondary) Shock
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)
9/12/20 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	September 12 1920
20-UNDERTAKER John M Weber	ADDRESS 1803 Bank

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046450

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046450

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 97 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Burke

(a) RESIDENCE. No. 604 Stump Alley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Burke

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Katie Washington

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed SEP 18 1920, 19 ACTING REGISTRAR Burial Permit Issued (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1920, to Sept. 10, 1920, that I last saw h alive on Sept. 9, 1920, and that death occurred, on the date stated above, at 6.55 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum. X-ray

(Signed) L. J. Cagney, M. D.

9-10-20, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Sept 13 1920
20 UNDERTAKER John H. Toadvine	ADDRESS 142 W Hill St

CAUSE OF DEATH must be filled in. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46451

D46451

36 D46451

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9th St Fairfield ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilson Grass

(Residence in Baltimore: No. 9th St Fairfield St.: 1 yrs., 11 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept (Month) 21 (Day), 1918 (Year)

7-AGE, 1 yrs. 11 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER, Wm Grass

11-BIRTHPLACE OF FATHER (State or Country). Cal. Co. Md

12-MAIDEN NAME OF MOTHER Lizzie Hinson

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Grass

(Address) 9th St Fairfield Md

15- FILED SEP 12 1920 ROBERT P. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 10 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Sept 10 1920, that I saw h.. alive on Sept 9 1920, and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

Rickets

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Diarrhea

(Duration) ....yrs. 2 mos. ....ds.

(Signed) W. H. Burnett M. D.

Sept 11, 1920 (Address) 1340 E. Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Sept 12 1920

20-UNDERTAKER John H. Jordan

ADDRESS 1132 W Fayette St

important. See instructions on back of certificate.

ec.—6-9-19—H. P. Co.—1000 Bks.

046452

HEALTH DEPARTMENT—CITY OF BALTIMORE

046452

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 1214 William St ST.: 24 WARD)

2-FULL NAME George H Gerhardt

• (a) RESIDENCE. NO. 1214 William ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 1 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) July 11 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Laboring

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George H Gerhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Regina Gerhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Regina Gerhardt
(Address) 1214 William St

15 Filed SEP 12 1920 WILLY F KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 9 1920, to Sept 10 1920, that I last saw h[illegible] alive on Sept 9 1920, and that death occurred, on the date stated above, at 2150 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓ unknown

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) D E Buxton M. D.

9. D. 1920 (Address) 301 East Lems St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Sept 13 1920
20 UNDERTAKER	ADDRESS
John J Fields	1200 W Lombard

Spec.—8-24-14—M. & T.—2000 Bks.

1046453 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046453

CERTIFICATE OF DEATH. 53

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 W. Madison ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Herman Feldman

(Residence in Baltimore: No. 222 W. Madison St. St.: 50 yrs.,.... mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, January 8th, 1857 (Month) (Day) (Year)

7-AGE, 63 yrs. 8 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Solicitor for Trusts & Estates
(b) General nature of industry, business, or establishment in which employed (or employer): Mercantile

9-BIRTHPLACE, (State or Country), Queen's Anne County Maryland

PARENTS.

10-NAME OF FATHER, John Charles Feldman

11-BIRTHPLACE OF FATHER (State or Country), Queen Anne's Co Maryland

12-MAIDEN NAME OF MOTHER Elizabeth Baally Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Susan Dorsey Horner

(Address) 222 W. Madison St

15- Filed SEP 12 1920, 191.... ROBERT B KRAUTER Registrar.

Burial Permit

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 11, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Sept 11 1920, that I saw h[illegible] alive on Sept 10 1920, and that death occurred, on the date stated above, at 40 m.

The CAUSE OF DEATH* was as follows:

Acute Lymphatic Leukemia (Leukemia)

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frederick Leute M. D.

9/11, 1920. (Address) 2020 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hermitage Cemetery Queen Town Queen Anne's Co

DATE OF BURIAL, 9-13-1920

20-UNDERTAKER Henry W. Jenkins Sons Co

ADDRESS Orchard and McCulloh St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1446454 | 1446454

REGISTERED NO. 15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Clarkson ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Leroy Taylor

(a) RESIDENCE. No. 1416 Clarkson ST., 23 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 23. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Aug 17, 20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 900

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Walter P. Taylor

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Nella M. Krause

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Walter P. Taylor
(Address) 1416 Clarkson

15 Filed SEP 12 1920 19 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that a ... TION is very important. See instructions on ... s on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 19, 1920, to Sept 11, 1920

that I last saw him alive on Sept 10, 1920

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Mal-Nutrition

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Ephemeration

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. L. Campbell, M. D.

Sept 11, 1920 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem Aa 6	Sept 13 1920
20 UNDERTAKER	ADDRESS
Mrs J. E. Evans & Sons	1428 Hanover St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 46455

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46455

CERTIFICATE OF DEATH.

165

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 N Glover ST.; 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Holland.

(a) RESIDENCE. No. 26 N. Glover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 7 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Edward S Holland

11 BIRTHPLACE OF FATHER (city or town) Balt
(State or country)

12 MAIDEN NAME OF MOTHER Barbra Benzinger

13 BIRTHPLACE OF MOTHER (city or town) Balt
(State or country)

14 Informant Edward S Holland
(Address) 26 N Glover

15 Filed SEP 12 1920 ROBERT F. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep - 12 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Sep - 10 - 1920, to Sep - 12 - 1920, that I last saw him alive on Sep - 12 - 1920, and that death occurred, on the date stated above, at 3:26 P.M.

The CAUSE OF DEATH* was as follows:

over

acute Gastritis

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY
(Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) William H. Johnson M. D.

Sept 12 1920 (Address) 2016 Guilford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept 14 1920
20 UNDERTAKER	ADDRESS
Wendell Hefflefinger & Son	378 Cumb

mation should be carefully supplied. Avoid abbreviations. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

0464456 0464456

CERTIFICATE OF DEATH.

78

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 N. Eutaw ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Lawrence Ricker

(a) RESIDENCE. NO. 521 N. Eutaw ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Fahey

6 DATE OF BIRTH (month, day, and year) Feb. 29, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	34	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber 059

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D. C.

PARENTS

10 NAME OF FATHER Robert Ricker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. D. C.

12 MAIDEN NAME OF MOTHER Catherine Nolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash. D. C.

14 Informant Josephine F. Ricker

(Address) 521 N. Eutaw Street

15 Filed SEP 12 1920 ROBERT P. KRAUTER Registrar

Burial Permit 61521

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/10 1920

17 I HEREBY CERTIFY, That I attended deceased from 8/26 1920 to 9/10 1920, that I last saw h— alive on 9/9 1920, and that death occurred, on the date stated above, at 11-45 A. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Hunt Clem M. D.

9/10, 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	9/13 1920
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

CAUSE OF DEATH must be given in plain terms. See instructions on back of certificates. TION is very important.

(over)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46457

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D46457

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2708 W. North Avenue ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Henrietta McDermott

(a) RESIDENCE. No. 2708 W. North Avenue ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Timothy McDermott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Henrietta Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Dooley
(Address) 2708 W. North Ave.

15 Filed SEP 12 1920 19 ROBERT B. BRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1920, to Sept 11, 1920, that I last saw h[illegible] alive on Sept 11, 1920, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis
Unknown
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hrt
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Sept 11, 1920 (Address) 2757 Wilmot Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	9/14, 1920
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain words. Do not use abbreviations or technical terms. Consult physician if necessary. Any false statement, concealment or omission of facts called for in this certificate may render the person making it liable to prosecution. See instructions on back of certificates. ATTENTION is very important.

over.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46458 HEALTH DEPARTMENT—CITY OF BALTIMORE D46458

CERTIFICATE OF DEATH. 9-091

1-PLACE OF DEATH Sydenham Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 304 N. Exeter ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME May Chovat

(a) RESIDENCE. No. 304 N. Exeter ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
5		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Morris Carat

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dina Dempsin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Morris Carat (Address) 304 N. Exeter St

15 Filed SEP 12 1920 19 ROBERT B. LANTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1920, to Sept 12, 1920, that I last saw him alive on Sept 12, 1920, and that death occurred, on the date stated above, at 2.50 a. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 10-20

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) B Blackwood, M. D.

, 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	Sept 12 1920

20 UNDERTAKER Jack Lewis ADDRESS 1411 E. Baltimore St

N. B.—WHITE should be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form 6-9-19 H. P. Co. 1000 Blks.

D46459

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D46459

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 43 S. Arlington ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon S. Matthews

(a) RESIDENCE. No. 43 S. Arlington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 9 ds. How long in U. S., if of foreign birth? yrs. 3 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James L. Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Taylors Is. Md.

12 MAIDEN NAME OF MOTHER Eliz. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hopewell Md

14 Informant Mr. James L. Matthews (Address) 43 S. Arlington

15 Filed SEP 13 1920 ROBERT N KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/11 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1920, to Sept 11, 1920, that I last saw her alive on Sept. 10, 1920, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. E. Seabury, M. D.

9/12 1920 (Address) 628 Fort.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	9/13 1920
20 UNDERTAKER	ADDRESS
S. F. McCully	130 E. Fort

CAUSE OF DEATH in plain terms, so that it may be classified. See instructions on back of certificates. TION is very important.

D46460 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046460

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore Dry Docks & Ship Building Co. South Plant. REGISTERED NO. C. 24 166

CITY OF BALTIMORE (No.) ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Elmer Elliott.

(Residence in Baltimore: No. 1420 Battery Ave. St.; ~~yrs.~~, / mos. —— ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, February 7th, 1896., 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
24 yrs. 7 mos. 3 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Caulker in.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... Ship yard. O15

9-BIRTHPLACE, (State or Country), Calvert Co. Md.

PARENTS.

10-NAME OF FATHER, David Elliott.

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co Md.

12-MAIDEN NAME OF MOTHER Emma Catton.

13-BIRTHPLACE OF MOTHER (State or Country), St Marys Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gladys L. Elliott. (wife).

(Address) 1420 Battery Ave.

15- Filed SEP 13 1920, 191... ROBERT B KRAUTER Registrar.
Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 10th, 1920, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns about face & Body.
Accidentally burned in a fire in
refrigerator room on S.S. Aeolus.
..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....
..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Bernhardt M. D. (Coroner.)
Sept. 12th 20, 191... (Address) 1511 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Broom's Island Md	9.13., 1920
20-UNDERTAKER	ADDRESS
I. F. McCully	130 E Fort Ave

N. B.—Every item of information must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

Stivers

D46461

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46461

103

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2113 E. Preston St.; 8 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Henry Stivers.

(Residence in Baltimore: No. 2113 E. Preston St. St.; (yrs., 55 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, July 6., 1865.
(Month) (Day) (Year)

7-AGE, 85. yrs. 2. mos. 5. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Blacksmith, 1906
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ohio,

PARENTS.

10-NAME OF FATHER, Clinton Stivers

11-BIRTHPLACE OF FATHER (State or Country), Ohio,

12-MAIDEN NAME OF MOTHER Hardman

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. John S. Hollstead

(Address) 2113 E. Preston ste.

15. SEP 13 1920 ROBERT P KRAUTER
Filed....., 191.... Registrar.

CAUSE OF DEATH to be plainly written, and important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 11, 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 11 1920, to Sept. 11 1920, that I saw him alive on — 1920, and that death occurred, on the date stated above, at 9.30 a. m.
The CAUSE OF DEATH* was as follows: 9.30 A.M.

Acute Indigestion

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) General Debility

(Duration) yrs. mos. 10 ds.

(Signed) C. M. Nelson M. D.

9.12., 1920. (Address) 1733 Hollins St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem.	Sept. 15., 1920.
20-UNDERTAKER	ADDRESS
Jas B. Cook	1003 W Balto St

Spec.—6-9-19—H. P. Co.—1000 Eks.

D46462 no number

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 D46462

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. 12th WARD)

2-FULL NAME Hazel Eberhart

(a) RESIDENCE. No. 609 Fleet Street ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 29-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Albert Eberhart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eva Preston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record
(Address) J. H. H.

15 Filed SEP 13 1920 ROBERT E. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11- 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 11- 1920, to Sept. 11- 1920,

that I last saw h.e. alive on Sept. 11- 1920,

and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) — yrs. — mos. 3 7 ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. C. Davison M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patrick Lens	Sept 13 1920
20 UNDERTAKER Joseph Ahrens	ADDRESS 221 N Bway

CAUSE OF DEATH in plain terms, so that no other cause can be substituted. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D46463 HEALTH DEPARTMENT—CITY OF BALTIMORE D046463

CERTIFICATE OF DEATH. 47

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Womans Hospital St.: 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Lettie Le Coney

(Residence in Baltimore: No. 2410 Shirley Ave St.; 29 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	married

6-DATE OF BIRTH, June (Month) 7 (Day) 1890 (Year)

7-AGE 30 yrs. 4 mos. 8 ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Philip E. Ratcliffe

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Roberta Simmons

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank L. Wolhenstein

(Address) Womens Hospital

15- Filed SEP 13 1920, 191. ROBERT B. KRAUTER Registrar. Burial Permit Given

CAUSE OF DEATH in plain terms. Omissions important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 10 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 23 1920, to Sept 10 1920, that I saw h[er] alive on Sept 10 1920, and that death occurred, on the date stated above, at 1.00 p.m.

The CAUSE OF DEATH* was as follows:

Pericarditis - acute -
C of Uremia.
(Duration) yrs. mos. 21? ds.

CONTRIBUTORY (Secondary) Rheumatic Fever
(Duration) yrs. 6? mos. ds.

(Signed) Frank L. Wolhenstein, M. D.
Sept. 10, 1920 (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 10 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence 2410 Shirley Ave, Balto.

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cem. | DATE OF BURIAL, Sept. 13, 1920

20-UNDERTAKER Wm. E. Blacke | ADDRESS 927 N. Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046464 1046464

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 North Mount ST.; 19 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian E. Hanssen

(Residence in Baltimore: No. 6 North Mount St.; — yrs., — mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, August (Month) 14 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
— yrs. — mos. 27 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... nod
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William H. Hanssen

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER Lillian Rendall

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H. Hanssen

(Address) 6 N. Mount St.

15- SEP 13 1920 ROBERT F KRAUTER
Filed..... 191... Burial Permit Clerk
Registrar.

CAUSE OF DEATH in plain terms. Uncertain terms or abbreviations will not be accepted. Every item important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 11 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10th 1920, to Sept 11th 1920, that I saw h[illegible] alive on Sept 11th 1920, and that death occurred, on the date stated above, at 10-20 P m.

The CAUSE OF DEATH* was as follows:

..... Mitral Obstruction

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs. 1 mos.....ds.

(Signed) W. H. Welch M. D.

Sept 12, 1920 (Address) 3005 St Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cemetery	Sept 13., 1920

20-UNDERTAKER	ADDRESS
Geo. A. Gerbig	2001 W. Baltimore St.

Dr W K. White 3005 St Paul st.

Spec.—8-24-14—M. & T.—2000 Blks.

2946465 HEALTH DEPARTMENT—CITY OF BALTIMORE 2946465

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. C 1440

CITY OF BALTIMORE: (No. 1514 Division St., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Judge Harris E. Sampley

(Residence in Baltimore: No. Hospital St.; ..... yrs., ... mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	White	Single

6-DATE OF BIRTH, July 22nd (Month) (Day), 1860 (Year)

7-AGE,	If LESS than 1 day,
60 yrs. 1 mos. 22 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Alabama.

PARENTS.

10-NAME OF FATHER, Dr. C. B. Sampley

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER, Thyrza Rudolf

13-BIRTHPLACE OF MOTHER (State or Country), Alabama

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C C Henderson

(Address) Greenville Alabama

15- Filed SEP 13 1920 191 ROBERT E KRAUTER Registrar. Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 13th (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 10th 1920, to September 13th 1920, that I saw h.. alive on September 13th 1920, and that death occurred, on the date stated above, at 7 45 A.m.

The CAUSE OF DEATH* was as follows:

General Carcinosis from Carcinoma of Stomach

(Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(Duration) ..... yrs. ..... mos. 16 ds.

(Signed) Joel Hinney Jr. M. D.

Sept. 13th, 1920. (Address) Union Memorial Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 ds. In the State ..... yrs. ..... mos. 4 ds.

Where was disease contracted, if not at place of death? At home

Former or usual residence Greenville, Alabama

19-PLACE OF BURIAL OR REMOVAL, Greenville Alabama — DATE OF BURIAL, Sept. 13 1920

20-UNDERTAKER John O Mitchell — ADDRESS 12 W. Fayette St.

1046466 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046466

CERTIFICATE OF DEATH.

137

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin St. Hospital St.: 70 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgie E. Jenkins

(Residence in Baltimore: No. 2528 Wilkens ave St.(yrs., 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	married

6-DATE OF BIRTH, Oct (Month) 25 (Day), 1884 (Year)

7-AGE, 35 yrs. 10 mos. 15 ds. If LESS than 1 day, ...hrs. or.....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home 037

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm R Moore

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Nellie I Buckingham

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas W. Jenkins

(Address) 2528 Wilkens ave

15- Filed SEP 13 1920, 191 ROBERT E KRAUTER Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 10 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Septicaemia following abortion
Acute Pancreatitis
Acute nephritis
(Duration) ..... yrs. ..... mos. 18 ds.

CONTRIBUTORY (Secondary) The Coroner assigns no
Causes. The abortion
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Fenton M. D. (Coroner.)

Sept 11, 1920 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place Franklin St Hos In the of death ....yrs. ....mos. 1 ds. State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....
2528 Wilkens ave

Former or usual residence 2528 E Wilkens ave

19-PLACE OF BURIAL OR REMOVAL, Good Shepherd, Howard Co Md — DATE OF BURIAL, Sept 13, 1920

20-UNDERTAKER Easton Sons. — ADDRESS Ellicott City.

N.B.—Every item of information should be carefully given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

046467 HEALTH DEPARTMENT—CITY OF BALTIMORE 046467

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2907 Hudson St. ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernst Herman Schultz

(a) RESIDENCE. No. 2907 Hudson ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora M. Schultz.

6 DATE OF BIRTH (month, day, and year) June 10-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 031

(b) General nature of industry, business, or establishment in which employed (or employer) Stationary engineer

(c) Name of employer Terminal Warehouse.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ernst Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Johanna Jauck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Dora M. Schultz. (Address) 2907 Hudson St.

15 Filed SEP 13 1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st 1920, to Sept 11, 1920, that I last saw him alive on Sept 10, 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH was as follows:

Phthisis Pulmonalis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hypertrophy of heart

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) M. J. McAvoy, M. D.

9/12 1920 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz's Cem.	Sept 14 1920

20 UNDERTAKER Tully and Finlen. ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046468 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046468

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 905 S. Sixth St. St.; 26 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Loeffler

(a) RESIDENCE. No. 905 S. Sixth St., 26 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Loeffler.

6 DATE OF BIRTH (month, day, and year) May 9—1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) City employee

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Loeffler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Loeffler. (Address) 905 S. Sixth St.

15 Filed SEP 13 1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11 1920

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to Sept 11, 1920, that I last saw h. alive on Sept 10, 1920, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Atrophic Cirrhosis of liver —

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilated heart

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M. W. Avery M. D.

9/12, 1920 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Sept. 14 1920
20 UNDERTAKER Lilly & Fuhr.	ADDRESS 403 S. Wolfe St.

BURIAL PERMIT. Fill out CAUSE OF DEATH in plain terms, so that it may be understood. Do not use abbreviations. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46469

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D46469

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 S. Linwood Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Mabel Bierman

(a) RESIDENCE. No. 724 S. Linwood Ave ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 27-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry C. Bierman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mollie Sundeland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Henry C. Bierman
(Address) 922 S. Potomac St.

15 Filed SEP 13 1920 19 ROBERT E. SLATTERY Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 1920

17

I HEREBY CERTIFY, That I attended deceased from July 14, 1920, to Sept 10, 1920.

that I last saw her alive on Sept 10, 1920.

and that death occurred, on the date stated above, at 6.00 P. m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis? Symptoms Signs

(Signed) C. Green, M. D.

19 (Address) 408 S. Bath Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Sept. 13 1920
20 UNDERTAKER Lilly and Fuhr.	ADDRESS 403 S. Broadway

If it may be property, so that it may be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D46470 HEALTH DEPARTMENT—CITY OF BALTIMORE D46470

CERTIFICATE OF DEATH. X 108

1-PLACE OF DEATH Bressler Pellman Hospital REGISTERED NO. C

CITY OF BALTIMORE: (No. 2724 N. Charles ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Lorayne Mc Vilbiss

(Residence in Baltimore: No. 14 E. Franklin St. St.; ...yrs., 9 mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, May (Month) 4 (Day), 1903 (Year)

7-AGE, 17 yrs. 4 mos. 4 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, James H. McIlvilbiss

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER Agnes ~~Doo~~

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. N. Elliott

(Address) 2503 N. Charles St Baltimore Md

15- Filed SEP 13 1920, 191... ROBERT B. KRAUTER Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 11 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6 1920, to Sept 11 1920, that I saw her alive on Sept 10 1920, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis following Influenza

Coma for several days previous

Asthenia Exhaustion

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) W. A. B. Sellman M. D.

Sept 11, 1920. (Address) 5 E Biddle St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Ellicott City

19-PLACE OF BURIAL OR REMOVAL, Ellicott City Md — DATE OF BURIAL, Sept 14, 1920

20-UNDERTAKER H M Routson — ADDRESS Greene & Saratoga Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified, is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D46471

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46471

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 Willow ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Lemaire

(a) RESIDENCE. NO. 808 Willow ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. 5 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Gable Lemaire

6 DATE OF BIRTH (month, day, and year): March 15. 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Robert Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizebeth Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Anna Murphy
(Address) 808 Willow St

15 Filed SEP 13 1920 Registrar

ROBERT A. LAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 10 1920

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1920, to Sept 10, 1920, that I last saw her alive on Sept 9, 1920, and that death occurred, on the date stated above, at 10.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tb

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Hornstein, M. D.

Sept 10, 1920 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Sept 14 20
20 UNDERTAKER	ADDRESS
William G. Schaffer	1816 Monument

Information should be carefully given, in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

1046472

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046472

CERTIFICATE OF DEATH.

115

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) Md. Gen'l Hospital ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Sackhoff

(a) RESIDENCE. NO. 611 Wyeth Street ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed, or Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mamie L. Sackhoff

6 DATE OF BIRTH (month, day, and year) March 1 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Presser 086

(b) General nature of industry, business, or establishment in which employed (or employer) for Strouss Brothers

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Sackhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Hedda Kohlmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Mamie L. Sackhoff
(Address) 611 Wyeth St

15 Filed SEP 13 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1920

17 I HEREBY CERTIFY, That I attended deceased from September 7 - , 1920, to September 11 , 1920, that I last saw him alive on September 11 , 1920, and that death occurred, on the date stated above, at 3:15 A m.

The CAUSE OF DEATH[c] was as follows:

Acute Cardiac Dilatation

6 hours.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyuria with Cholecystitis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Sept 10, 1920

Was there an autopsy? No

What test confirmed diagnosis? Clinical Manifestations

(Signed) R. H. Richardson, M. D.

(Address) Md. Gen'l Hospital

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Sept 14 1920

20 UNDERTAKER: Jos Jacobs & Son — ADDRESS: 2078 Penn

Burial permit Clerk

mation should be carefully answered. ... it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D46473 HEALTH DEPARTMENT—CITY OF BALTIMORE D46473

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 120

CITY OF BALTIMORE: (No. 319 S Fulton Ave St.; 19 WARD)

(If death occurred in a hospital or Institution, give Its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Mary Taylor

(Residence in Baltimore: No. 319 S Fulton ave St.; 5 yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March (Month) 4 (Day) 1880 (Year)

7-AGE, 40 yrs. 7 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, — Day

11-BIRTHPLACE OF FATHER (State or Country) Md.

12-MAIDEN NAME OF MOTHER dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Taylor

(Address) 319 S. Fulton Ave

15- SEP 13 1920 ROBERT B KRAUTER Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 9 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 10 1920, to Septemb 9 1920, that I saw h-r alive on Sept 9 1920, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

1 Cr Intestinal Nephritis

2

3 Endocarditis

(Duration) Years Mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 1 ds.

(Signed) Robert C Mitze M. D.

Sept 13., 1920 (Address) 1151 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Sept 13., 1920

20-UNDERTAKER Harry H Witzke — ADDRESS 1531 W Lemmon

N. B.—Every item in CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

1046474 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046474

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore Dry Docks & Ship

CITY OF BALTIMORE (No. Building Co. South Plant. St.: 24 WARD) REGISTERED No. C 166

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Seipp.

(Residence in Baltimore: No. Lansdowne Md. St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, Do not know. (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
41 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Burner in Oil
(b) General nature of industry, business, or establishment in which employed (or employer): Ship yard.

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, George Seipp.

11-BIRTHPLACE OF FATHER (State or Country). Pennsylvania

12-MAIDEN NAME OF MOTHER Elizabeth Carey.

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles W. Seipp. (brother).

(Address) 2012 Madison Ave.

15-SEP 13 1920 Filed, 191.. Burial Permit Given. BOWERS & KRAUTER Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated in years, months and days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 10th, 1920, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to b.i.d death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns about face & body.
Accidentally burned in a fire in refrigerator room on S.S. Aeolus.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto Reinhardt M. D. (Coroner.)

Sept. 12, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	9/13/20.., 19...
20-UNDERTAKER John J Fahey & Sons	ADDRESS 1318 Light St

Spec.—6-9-19—H. P. Co.—1000 Blks.

1046475 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046475

CERTIFICATE OF DEATH. 115

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Harrison

(a) RESIDENCE. No. 1015 Light St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46476

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 D46476

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2805 Guilford av ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann A. Griffith

(a) RESIDENCE. No. 2805 Guilford av ST., WARD. Buffalo N.Y.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Frank J Griffith

6 DATE OF BIRTH (month, day, and year) May 3, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brooklyn N.Y.

PARENTS

10 NAME OF FATHER William W Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Elizabeth Bush

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Long Island

14 Informant Thomas W. Walsh

(Address) 2805 Guilford av

15 Filed SEP 13 1920 19.... ROBERT E KLAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 1919, to Sept 13, 1920, that I last saw her alive on Sept 12, 1920, and that death occurred, on the date stated above, at 2 30 a m.

The CAUSE OF DEATH* was as follows:

Toxaemia (Coma) from General Carcinoma (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma bladder (duration) 1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Buffalo N.Y.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cystoscopic exam

(Signed) Hiram Buckley M. D.

, 19 (Address) 806 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Buffalo New York	Sept 13 1920

20 UNDERTAKER ADDRESS

John B. Spence 1325 N Caroline St

mation should be carefully supplied. Any information which it may be properly classified. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

046477

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

046477

645

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 103 West West ST.: 23 WARD)

2-FULL NAME Samuel Newman

(a) RESIDENCE. No. 103 West West ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sara Newman

6 DATE OF BIRTH (month, day, and year) March 4 - 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 086

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer retired

9 BIRTHPLACE (city or town) (State or country) Washington DC.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Annie Gibbs
(Address) 103 West West St

15 Filed SEP 13 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10th 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 23rd, 1919, to Sept 10, 1920, that I last saw h[illegible] alive on Sept 1, 1920, and that death occurred, on the date stated above, at 5:45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) General debility

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? ~

(Signed) [illegible] Burton, M. D.

9/11. 1920 (Address) 351 East Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible] Cemetery	Sept 13 1920
20 UNDERTAKER Edmund Lemley	ADDRESS 078 [illegible]

TION is very important. See instructions on back

A046478 HEALTH DEPARTMENT—CITY OF BALTIMORE A046478

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 5682 N. Fulton Ave

CITY OF BALTIMORE (No. Russell Jackson ST.: 17 WARD) 150 REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Russell Jackson

(Residence in Baltimore: No. 5682 N. Fulton St.; yrs., 1 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	Single

6-DATE OF BIRTH, August 9, 1920 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs. 1 mos. 3 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none 880
(b) General nature of industry, business, or establishment in which employed (or employer)..... (Infant)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, William Jackson

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Eula Jackson

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eula Jackson

(Address) Virginia

15-

Filed SEP 13 1920 191.... ROBERT B KRAUTER Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 12, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or, inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. J. T. Hennessy M. D. (Coroner.)

Sept. 12, 1920 (Address) 2802 Eldorado

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cem	Aug 13 1920
20-UNDERTAKER, Hyman & Bowles	ADDRESS 1700 E Balto

Every item of information should be carefully supplied. AGE should be stated EXACTLY. If unknown, it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be

Spec.—8-24-14—M. & T.—2000 Blks.

D46479

HEALTH DEPARTMENT—CITY OF BALTIMORE

130 D46479

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 E 22nd St. ; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L Fields

(Residence in Baltimore: No. 817 E 22nd St. 5 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July 29, 1870 (Month) (Day) (Year)

7-AGE. 50 July yrs. 1 mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Policeman
(b) General nature of industry, business, or establishment in which employed (or employer)..... 061

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Chas L. Fields

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Mary Suter

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Chas Fields

(Address) 817 E 22nd St

15- SEP 13 1920 ROBERT F FLAUTH Burial Permit Clerk

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 11th, 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 5th 1920, to September 11th 1920, that I saw h alive on September 2nd 1920, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

1. Chronic Interstitial Nephritis

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) ..... yrs. ..... mos. 7 ..... ds.

(Signed) D E Fahy M. D.

Sept 11th 1920. (Address) 817 E 22nd St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL. Holy Redeemer DATE OF BURIAL. Sept 13 1920

UNDERTAKER E. A. Weidefeld Jr. ADDRESS 22nd & Guilford Ave

N.B.—Every item of information should be given as far as possible, so that it may be properly classified. Each statement should be full and complete, so that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

1046480

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046480

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2330 E. Fayette St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest Pritchett

(Residence in Baltimore: No. 2330 E. Fayette St.; ..... yrs., 13 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug. 11 st (Month) (Day), 1919 (Year)

7-AGE, 1 yrs. 1 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Harris Pritchett

11-BIRTHPLACE OF FATHER (State or Country). Dorchester Co. Md

12-MAIDEN NAME OF MOTHER Isabel Graves.

13-BIRTHPLACE OF MOTHER (State or Country). St Marys Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harris Pritchett

(Address) 2330 E. Fayette St

15-

Filed....., 191.....

ROBERT E KRAUTER
Registrar.

SEP 13 1920
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep. (Month) 12 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1920, to Sep. 12, 1920, that I saw him alive on Sep. 11, 1920, and that death occurred, on the date stated above, at 12.10 P. m.

The CAUSE OF DEATH* was as follows:

Pleo Colitis

(Duration) ....yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary).....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Eugene L. Pessagno M. D.

Sep. 13, 1920. (Address) 2314 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem — DATE OF BURIAL, Sept. 13, 1920

20-UNDERTAKER Jas. C. Miller — ADDRESS 2334 Jefferson St

N.B.—Every item of information should be carefully given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46481

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46481

91-081

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST.; WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Coleman

(a) RESIDENCE. No. 3027 McElderry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Coleman

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) 032

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant City Hospital Records
(Address)

15 Filed SEP 13 1920 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1920

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to Sept 12, 1920, that I last saw him alive on Sept 12, 1920 and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic Exam

(Signed) George T. Gwynn Medairy M. D.

. 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	Sept 15 1920
20 UNDERTAKER	ADDRESS
Jas C. Diller	2834 Jefferson

N. B.—WRITE LEGIBLY. All information should be carefully supplied. AGE should be stated in years. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY. WITH INK. N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

L046482 HEALTH DEPARTMENT--CITY OF BALTIMORE 8-9 L046482

CERTIFICATE OF DEATH

REGISTERED NO. C .....

(PLACE OF DEATH

CITY OF BALTIMORE (No. 3707 Centre Place Highland Ter ST.: 26 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milton Lindeman

(Residence in Baltimore: No. 3707 Centre Place St. 1 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: May (Month) 21 (Day), 1919 (Year)

7-AGE: 1 yrs. 3 mos. 23 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10-NAME OF FATHER: Charles J Lindeman

11-BIRTHPLACE OF FATHER (State or country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Margaret Engel

13-BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles J Lindeman

(Address) 3707 Centre Place

15- SEP 13 1920 Filed ....., 191.... ROBERT B KRAUTER Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept. (Month) 13 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 12, 1920, to Sept 13 1920, that I saw h-im alive on Sept 13, 1920, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Whooping Cough (Pertussis)

..... (Duration) ..... yrs. ..... mos. 14 ds

Contributory (SECONDARY) Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) ..... M. D.

Sept 13, 1920 (Address) 930 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Green Mount Cemetery

DATE OF BURIAL: Sept 14, 1920

20-UNDERTAKER: Wm C. Miller

ADDRESS: 2334 Jefferson St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46483 D46483

CERTIFICATE OF DEATH.

104

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 S. Bond ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislawa Skarbek

(Residence in Baltimore: No. 420 S. Bond St., 1 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... Nov. (Month) ..... 20 (Day) ....., 1919 (Year)

7-AGE,	If LESS than 1 day,
..... yrs. 0 mos. 22 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00 .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jacek Skarbek

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Julia Cieminska

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacek Skarbek

(Address) 420 S. Bond St.

15- SEP 13 1920 Filed....., 191.... ROBERT N KRAUTER Burial Permit Recorder.

N. B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 13 (Month) (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Sept. 10 1920, to Sept. 12 1920, that I saw h[illegible] alive on Sept. 12 1920, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

..... Dropsy .....

..... (Duration) 0 yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) ..... Interstitial Nephritis .....

..... (Duration) ..... yrs. ..... mos. 12 ds.

(Signed) ..... M. D.

Sept. 13, 1920 (Address) 722 S. Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary Cem.	Sept. 14..., 1920
20-UNDERTAKER	ADDRESS
Jacob Faltkowski	428 S. Bond St.

Spec. 5-9-19—H. P. Co.—1000 Bks.

D46484

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46484

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 332 S. Poppleton ST. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Nagel

(a) RESIDENCE. NO. 332 S. Poppleton St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles W. Nagel.

6 DATE OF BIRTH (month, day, and year) Sept. 5. 1888.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house work. 037

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Emrick.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mr Charles W Nagel.
(Address) 332 S. Poppleton Street.

15 Filed SEP 13 1920 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-11- 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 . 1920. to Sept 11 . 1920.
that I last saw h— alive on Sept 11 . 1920
and that death occurred, on the date stated above, at 7.30 a m.
The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Oedema

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Davis, M. D.
9/11/1920 (Address) 1211 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery,	Sept 14. 1920
20 UNDERTAKER	ADDRESS
John J. Cowan & Son.	901 Hollins.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated correctly. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be understood by the layman. See instructions on back of certificates. DATE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046485

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046485

CERTIFICATE OF DEATH.

REGISTERED NO. 81

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 S. Calhoun St. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Sommers.

(a) RESIDENCE. No. 311 S. Calhoun St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown.

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66.	"	"	

8 OCCUPATION OF DECEASED 040

(a) Trade, profession or particular kind of work street cleaning.

(b) General nature of industry, business, or establishment in which employed (or employer) street cleaning dept.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John Sommers.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Sinnott.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mr William Sommers
(Address) 311 S. Calhoun St.

15 Filed SEP 13 1920 19 BOBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-11- 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to Sept 11, 1920.

that I last saw h alive on Sept 11, 1920.

and that death occurred, on the date stated above, at 2.20 m.

The CAUSE OF DEATH* was as follows:

Acute Interst Nephritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilford D Davis, M. D.

Sept 13 1920 (Address) 1220 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery.	Sept 14, 1920
20 UNDERTAKER John J. Cowan & Son.	ADDRESS 901 Hollins.

N. B.—WRITE PLAINLY. Words must be spelled out. AGE should be stated in years, months and days if under one year. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified

D46486 HEALTH DEPARTMENT—CITY OF BALTIMORE D46486

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore Dry Docks & Ship

CITY OF BALTIMORE (No. Building Co. South Plant. ST.: 26 166 WARD) REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Ravadge.

(Residence in Baltimore: No. Bowleys Lane. Raspeburg Md. St.; 49 yrs., 8 mos., 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, January 6th 1871, 1 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
49 yrs. 8 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter in S
(b) General nature of industry, business, or establishment in which employed (or employer): Shipyard.

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Ravadge.

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER Catherine Bowman.

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Ravadge. (wife)

(Address) Raspeburg Md.

15- SEP 13 1920 BOBERT E KRAUTER
Filed ....., 191.... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 10th, 1920. (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns about face & body.
Accidentally burned in a fire in refrigerator room on S.S. Aeolus.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Chas. P. Leonard M. D. (Coroner.)

Sept. 12th, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Sept. 14th 19 20
20-UNDERTAKER	ADDRESS
Frank Lassahn & Sons	Fullerton Md.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

46487

HEALTH DEPARTMENT—CITY OF BALTIMORE

46487

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 608. S. Bethel ST.: V WARD)

2-FULL NAME Genovefa. Majgraf.

(a) RESIDENCE. NO. 608. S. Bethel ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 6m yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 24-1919

7 AGE: Years 1; Months; Days 21; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore.

PARENTS

10 NAME OF FATHER: Wicenty Majgraf

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Agt. Waszczuk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant (Address): Wicenty Majgraf. 608 S. Bethel

15 Filed SEP 14 1920 ..... 19 ..... ROBERT J. LEATHERBURY Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/12-20 19

17 I HEREBY CERTIFY, That I attended deceased from 9/8/20, 19..... to 9/12/20, 19....., that I last saw h[illegible] alive on 9/12/20, 19....., and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? reported Widal Test

(Signed) A. J. Ammen M. D.

(Address) 1916 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Sept. 14 1920

20 UNDERTAKER: William Fallsowski — ADDRESS: 1618 Eastern

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of facts is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

46488 HEALTH DEPARTMENT—CITY OF BALTIMORE 10404 46488

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 708 S. Bethel ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. Dziecionticko

(a) RESIDENCE. No. 708. S. Bethel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March - 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Adam Dziecionticko

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Okisiak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant A. Dziecionticko
(Address) 708 S Bethel

15 Filed SEP 14 1920 ROBERT P. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10th, 1920, to Sept 12, 1920, that I last saw him alive on Sept. 12, 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Mary Hermann M.D., M. D.

, 19 (Address) 1707 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Sept. 14 1920
20 UNDERTAKER	ADDRESS
Wm Faulstich	1618 East

N. B.—WRITE PLAINLY. All items must be carefully supplied. AGE should be given in years, months and days. If less than one day, hours or minutes. Exact information should be carefully supplied. AGE should be given in years, months and days. If less than one day, hours or minutes. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease may be necessary. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

46489 HEALTH DEPARTMENT—CITY OF BALTIMORE 46489

CERTIFICATE OF DEATH. 8-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005, Curtis Ave ST.: 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances. Sodomorg

(a) RESIDENCE. No. 1005 Curtis Ave ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Sing G.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 22 - 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel. Sodomorg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jalisco Austria

12 MAIDEN NAME OF MOTHER Elizabeth Ciletta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jalisco Austria

14 Informant Simon. Sodomorg.

(Address) 1005 Curtis Ave.

15 Filed SEP 14 1920 ROBERT F KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1920, to Sept 10, 1920, that I last saw her alive on Sept 10, 1920, and that death occurred, on the date stated above, at 6.05 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Leon D. Hurtt M. D.

Sept 13 1920 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross. R.R.Co.	Sept 14 1920

20 UNDERTAKER	ADDRESS
Mt Hall Cowdrey & Son	1618 Eastern Ave

N. B.—WRITE PLAINLY, with pen and ink. ALL BLANKS should be carefully supplied. AGE should be stated at last birthday. Exact statement of occupation may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

46490

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 63 / 46490

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3008 Clifton Ave. ST.: 15 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Hurkley Clarke

(Residence in Baltimore: No. 3008 Clifton Ave St.: yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married Catherine Croft Clarke

6-DATE OF BIRTH: Aug (Month) 23 (Day), 1871 (Year)

7-AGE: 49 yrs. mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Tobacco Tester 086
(b) General nature of industry, business, or establishment in which employed (or employer): F. C. Lisle Hamilton & Co 182 Pearl St. N.Y. N.Y.

9-BIRTHPLACE (State or country): Wisconsin

PARENTS

10-NAME OF FATHER: Wm H. Clarke

11-BIRTHPLACE OF FATHER (State or country): N.Y.

12-MAIDEN NAME OF MOTHER: Anna Bates

13-BIRTHPLACE OF MOTHER (State or country): N.Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. V. Baugh

(Address) 3008 Clifton Ave.

15- SEP 14 1920 Filed ..... 19.. ROBERT B KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept (Month) 13th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 10th, 1920, to Sept 13th 1920, that I saw him alive on Sept 12th, 1920, and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Ascending Myelitis

(Duration) 3 yrs. mos. ds

Contributory (SECONDARY) General Paralysis

(Duration) 1 yrs. 6 mos. ds.

(Signed) Herbert E. Sept M. D.

Sept 13th, 1920. (Address) 305 W. Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence: Wisconsin

19-PLACE OF BURIAL OR REMOVAL: Edgerton Wis. DATE OF BURIAL: Sept 14, 1920

20-UNDERTAKER: W J Tuberculosis ADDRESS

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046491 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046491

CERTIFICATE OF DEATH. 24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST.: 20 WARD)

2-FULL NAME Edward Hartman

(a) RESIDENCE. No. 540 Brice ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12, 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Hartman

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Florence Paul

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Edward Hartman
(Address) 540 N. Brice St.

15 Filed SEP 14 1920 ROBERT E. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1920, to Sept 12, 1920, that I last saw h/m alive on Sept 12, 1920, and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

Vaccination

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tetanus

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lyman D. Abbott, M. D.

, 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 14 1920

20 UNDERTAKER Jos B Cook ADDRESS 1038 Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK. PENCIL WILL NOT COPY. All information should be carefully supplied. AGE should be stated EXACTLY. Physicians' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

046492

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

172 046492

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Julia Farrell

(a) RESIDENCE. No. 504 Macher St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 45 yrs. — mos. — ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word) Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing do

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Michall Conner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Kelly (Address) 507 Hooker St

15 Filed ..... 19 .....

SEP 14 1920 BUREAU OF VITAL STATISTICS Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1920

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1920, to Sept 10, 1920, that I last saw h[illegible] alive on Sept 10, 1920, and that death occurred, on the date stated above, at 9:05 m.

The CAUSE OF DEATH* was as follows:

Fracture of left femur tibia & fibula

(duration) yrs. 1 mos. 22 ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W McKlang M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Sep 14 1920

20 UNDERTAKER Martin Fahey & Sons ADDRESS 1827 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. The Statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. OCCUPATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046493. HEALTH DEPARTMENT—CITY OF BALTIMORE 1046493.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospt ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Pledge.

(a) RESIDENCE. No. 2413 N North ave Balt Md ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	widower

5a If ~~married, widowed, or divorced~~ HUSBAND ~~(or) WIFE~~ of Widowed

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
77				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gettysburg Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Rosa Pledge

(Address) 2413 N North Ave

15 Filed SEP 14 1920 19 ROBERT F KRAMER Registrar

Burial Permit Oleg

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1920, to Sept 12, 1920, that I last saw him alive on Sept 12, 1920, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Fracture of femur

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Middleton M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sep 15 1920

20 UNDERTAKER Martin Fahey & Sons ADDRESS 1827 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46494

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D46494

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Vincent Asylum ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Waters

(a) RESIDENCE. NO. St Vincent Asyle ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 15 1920

7 AGE Years	Months	Days	If LESS than 1 day ...hrs. or ...min.
—	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Sr Matthew

(Address) St Vincent Asy

15 Filed SEP 14 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 31, 1920, to Sept 8, 1920, that I last saw h alive on Sept 8 1920, and that death occurred, on the date stated above, at 8 30 a. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas P Cleaver M. D.

Sept. 10 1920 (Address) 1504 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Sept 14 1920

20 UNDERTAKER Martin Staley Son ADDRESS 1827 W N

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

1046495 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046495

X 109 V

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Bishop

(Residence in Baltimore: No. 1403 Mosher St.: yrs., mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR ~~DIVORCED~~, (*Write* the word.)
M	b	Single

6-DATE OF BIRTH, Feb 24, 1904
(Month) (Day) (Year)

7-AGE, 16 yrs. 6 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Calvert Co Md

PARENTS.

10-NAME OF FATHER, Prince A Bishop

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Florence Watts

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Prince A. Bishop

(Address) Calvert Co Md

15- Filed SEP 14 1920 191.... ROBERT B KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 12-, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gunshot Peritonitis

(Duration) yrs. mos. 1 ds.

(Signed) Geo Blum Bates M. D.
(Coroner)

9/13/20 191.. (Address) 439 E. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Fallsington Calvert Co Md

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL, Sept. 14, 1920
Soldiers Hy Calvert Co Md	
20-UNDERTAKER Sam'l H. Case & Son	ADDRESS 1400 Mosher

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046496

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154

1046496

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 518 Scott St. ST. 21 WARD)

2-FULL NAME Brezzentia Wallnöfer

(a) RESIDENCE. No. 518 Scott St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caspar Wallnofer

6 DATE OF BIRTH (month, day, and year) Mar 25 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Fidel Bentele

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Crescentia Wallnöfer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anton Wallnöfer

(Address) 518 Scott St.

15 Filed SEP 14 1920 16 ROBERT E. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 3rd, 1920, to Sept 12, 1920, that I last saw h.er alive on Sept 11, 1920, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Senile Decay

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Emmerken, M. D.

9/14, 1920 (Address) 517 Lead n.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Most Holy Redeemer Cemetery DATE OF BURIAL Sept 15 1920

20 UNDERTAKER H. Kender & Son ADDRESS 1710 Fleet St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Kimmerle

HEALTH DEPARTMENT—CITY OF BALTIMORE

L 46497 L 46497

CERTIFICATE OF DEATH.

92-079

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Kimmerle

(Residence in Baltimore: No. 2441 Fleet St.; 64 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, April 20th (Month) (Day), 1856 (Year)

7-AGE. 64 yrs. 4 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country), Balto City Md.

PARENTS.

10-NAME OF FATHER, Frederick Kimmerle

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Pieler

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Kimmerle

(Address) 2441 Fleet St

15- SEP 14 1920 ROBERT B KRAUTER

Filed....., 191.. BURIAL PERMIT Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 12, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 11 1920, to Sept 13 1920, that I saw h[illegible] alive on Sept 13 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

[illegible]

Myocardial Degeneration

(Duration)....yrs....mos....6....ds.

CONTRIBUTORY (Secondary) Pneumonia (Lobar)

(Duration)....yrs....mos....2 0....ds.

(Signed) [illegible] M. D.

Sept. 13, 1920. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 2 ds. In the State 64 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 2441 Fleet St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
1st Evangelical Cem.	Sept. 16, 1920.
20-UNDERTAKER H. Sander Sons	ADDRESS 1710 Fleet St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46498 — 120 D46498

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316 S Washington ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Dorothy Macker Mightson

(a) RESIDENCE. NO. 316 S Washington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced (or) WIFE of Milford D. Mightson

6 DATE OF BIRTH (month, day, and year) Jan 24 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Chas H Macker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland.

12 MAIDEN NAME OF MOTHER Harriet E Barker.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Milford D Mightson (Address) 316 S Washington St.

15 Filed SEP 14 1920 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 31 1918 to Sept 11 1920.

that I last saw her alive on Sept 11 1920.

and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

about 2 yrs. mos. ds.

(duration)

CONTRIBUTORY (Secondary) — —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Geo Keller, M. D.

9-13 1920 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Sept 14 1920

20 UNDERTAKER: H E Stephens — ADDRESS: 17 S Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46499

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46499

+126

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home and Infirmary ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Payne Anderson

(a) RESIDENCE. NO. Heathsville, Va. ST.. WARD. Heathsville Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 19-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wheelwright 007

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ann Langford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Capt J. Anderson (Address) Heathsville Va.

15 Filed SEP 14 1920 19 ROBERT I. CRAWFORD Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1920, to Sept. 12, 1920 that I last saw him alive on Sept. 12, 1920, and that death occurred, on the date stated above, at 11:25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Prostatic Hypertrophy with retention of urine, Cystitis & general toxaemia.

(duration) yrs. mos. 41 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Heathsville, Va.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter T. Anderson, M. D.

Sept. 13, 1920 (Address) Church Home and Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loan Va.	Sept 15 1920

20 UNDERTAKER H E Hughes ADDRESS 17 S Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

1046500

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046500

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 Ramsay St.) 1979 (WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. IN.)

2-FULL NAME Benjamin Knell

(Residence in Baltimore: No. 1523 Ramsay St.; 67 yrs., 9 mos. 14 ds.)

WRITE PLAINLY, WITH UNFADING INK.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH, Jan. 30, 1852 (Month) (Day) (Year)

7-AGE, 67 yrs. 9 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brass Finisher
(b) General nature of industry, business, or establishment in which employed (or employer): Goldsher 610

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Andrew Knell

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Josephine Feghmann

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josephine Davis

(Address) 1523 Ramsay St

15-

Filed SEP 14 1920, 191 ROBERT B KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 13th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1920, to Sept 13 1920, that I saw him alive on Sept 12 1920, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

Heart (Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. C. Knell M. D.

Sept. 14, 1920 (Address) 130 S. Gilmor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Cathedral Cemetery	Sept. 16, 1920
20-UNDERTAKER	ADDRESS
Knell & Son	1229 W Pratt St

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046501

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046501

CERTIFICATE OF DEATH.

89

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2829 Remington ST.: 12 WARD)

2-FULL NAME. Cecelia Norris

(a) RESIDENCE. NO. 2829 Remington ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 12, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Matthew Wynder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Cyrus Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Cyrus Wynder

(Address) 2829 Remington Ave

15 Filed SEP 14 1920, 19 ROBERT P. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1920, to Sept 13, 1920.

that I last saw h— alive on Sept 13, 1920.

and that death occurred, on the date stated above at 11 A.m.

The CAUSE OF DEATH* was as follows: Acute Bronchitis

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Teething

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) R. Garland Thrush M. D.

. 19 (Address) 1534 - 2 St. E.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery	Sept 14 1920
20 UNDERTAKER Mrs Robt A Wolfe	ADDRESS 1725 Ashland Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1046502 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046502

CERTIFICATE OF DEATH. 39

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.; W. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. James Raan

(a) RESIDENCE. NO. 1111 Bristol ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9/15/1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
48	47	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Horace Roan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Henritta Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): James Raan 1111 Bristol St

15 Filed SEP 14 1920 ROBERT S. LEATHERBURY Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/10 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 6 . 1920 . to Sept 10 . 1920 . that I last saw him alive on Sept 10 . 1920 . and that death occurred, on the date stated above, at 11:40 a.m.

The CAUSE OF DEATH* was as follows:

Epithelioma of the tongue (Malignant)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Shock from Operation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 9/10/20

Was there an autopsy? No

What test confirmed diagnosis? Pathological

(Signed) W. D. Baer, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	Sept 14 20
20 UNDERTAKER	ADDRESS
Planet Eastern	916 Penna Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. [illegible] should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046503 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046503

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.: 14 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Brown

(a) RESIDENCE. No. 433 Mosher St St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work no

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Charles Lembleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Brown (Address) 433 Mosher St

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1920, to Sept 12, 1920, that I last saw h w alive on Sept 12, 1920, and that death occurred, on the date stated above, at 8.30 p.m.

The CAUSE OF DEATH* was as follows:

Bronchos Pneumonia

Primary (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? none

What test confirmed diagnosis? none

(Signed) J. W. Prentiss M. D

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 14 1920
20 UNDERTAKER Daniel Eaton	ADDRESS 196 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

SEP 14 1920 Registrar's Clerk

D46504 HEALTH DEPARTMENT—CITY OF BALTIMORE 15 D46504

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1708 Hartford ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Hoyt.

(Residence in Baltimore: No. 1708 Hartford St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
F.	White	Infant

6-DATE OF BIRTH, Sept 13, 1920. (Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work — (Child)
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER James Hoyt.

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Anna Pittsfadt

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James J. Hoyt

(Address) 1708 Hartford

15-

SEP 14 1920

Filed ....., 191.... ROBERT J. KNAUER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 13, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia Livida 3 hrs.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prolonged Delivery 3 hrs.

(Duration) yrs. mos.

(Signed) Jno. Edmund Blade M. D. (Coroner.)

9/13/20 191... (Address) 1436 Bray

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Schwartz Cem	Sept 17 19.
20-UNDERTAKER J Herwig & Co	ADDRESS 1008 Arlington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

046505 HEALTH DEPARTMENT—CITY OF BALTIMORE 046505

CERTIFICATE OF DEATH. 103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4702 Charles Ave. Lemaville ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Boughter

(a) RESIDENCE. No. 4702 Charles Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. — mos. — ds. How long in U. S., if of foreign birth? 64 yrs. 9 mos. 20 ds.

MARGIN RESERVED—N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Jane E. Boughter.

6 DATE OF BIRTH (month, day, and year) November 23rd 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Employed last for 8b

(b) General nature of industry, business, or establishment in which employed (or employer) Boyle Canning Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md.

PARENTS

10 NAME OF FATHER Thomas Boughter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Tate.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Jane E. Boughter. (Address) 4702 Charles Ave Lemaville Md.

15 Filed SEP 14 1920, 19 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 1920

17 I HEREBY CERTIFY, That I attended deceased from August 30, 1920, to Sept 13, 1920, that I last saw him alive on Sept 13, 1920, and that death occurred, on the date stated above, at 12 15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Arthritis extending over a period of several years

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General Conditions

(Signed) H. Young Muthrot, M. D.

19 (Address) 1317 Hanover ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Centre M. E. Church Cemetery Forrest Hill Cemy.	Sept. 15 19 20
20 UNDERTAKER Henry Hoeck Son	ADDRESS 1301 E Eager St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

0466506 HEALTH DEPARTMENT—CITY OF BALTIMORE 0466506

CERTIFICATE OF DEATH.

104 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1114 N. 36th St. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert E. Phillips

(Residence in Baltimore: No. 1114 N. 36th St.

St.: yrs., 6 mos. 29 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word)
Male	White	Single

6-DATE OF BIRTH, Feb. 14, 1920
(Month) (Day) (Year)

7-AGE, — yrs. 6 mos. 29 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Wm. E. Phillips

11-BIRTHPLACE OF FATHER (State or Country) Balto. Co. Md.

12-MAIDEN NAME OF MOTHER Ida V. Goodrich

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. E. Phillips

(Address) 1114 N. 36th St

15-

Filed SEP 14 1920, 191 ROBERT B KRAUTER
Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the date stated above.

The CAUSE OF DEATH was as follows:

Intestinal Obstruction

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] (Coroner.) M. D.

Sept 13 1920 (Address) 363 Robert

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt. Mary (Hampden) DATE OF BURIAL, Sept. 14, 1920

20-UNDERTAKER Horace Burgee & Son ADDRESS 3631 Falls Rd

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046507

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046507

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital WARD) 20

REGISTERED NO. 172

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Harriett Logue

(a) RESIDENCE. No. 4005 Edmondson Av. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A Logue

6 DATE OF BIRTH (month, day, and year) Mar 6-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John S. Lucas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Miss Mary Logue

(Address) 4005 Edmondson Ave

15 Filed SEP 14 1920, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1920

17

I HEREBY CERTIFY, That I attended deceased from 8-6-, 19 20 to 9-13, 19 20

that I last saw her alive on 9-13, 19 20

and that death occurred, on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH* was as follows:

fracture of femur.

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia hypostatic

(duration) yrs. mos. 3 ds.

18 Where was disease contracted If not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Will C Kemp, M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL / DATE OF BURIAL

Cathedral Sept 16 1920

20 UNDERTAKER / ADDRESS

H. C. Wiedefeld 914 Fremont Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidental fall on floor at her home

Spec.—8-24-14—M. & T.—2000 Bks.

D46508

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46508

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2110 W. Fairmount av ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo W. Wood

(Residence in Baltimore: No. 2110 W. Fairmount av St.; 50 yrs., 1 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, July (Month) 25 (Day), 1870 (Year)

7-AGE, 50 yrs. 1 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Buyer & Producer
(b) General nature of industry, business, or establishment in which employed (or employer): Commission House

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Lawrence Wood

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Luanda Bunn

13-BIRTHPLACE OF MOTHER (State or Country), N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hilda R. Wood

(Address) 2110 W. Fairmount Ave

15- Filed SEP 14 1920 ROBERT P. PRAETER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep (Month) 12 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 12 1920, to Sep 12 1920, that I saw h.. alive on Sep 12 1920, and that death occurred, on the date stated above, at 11 30 m.

The CAUSE OF DEATH* was as follows:

(a) Chronic myocarditis and

(b) Arterio sclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia and apoplexy

(Duration) yrs. mos. 1 ds.

(Signed) Bruce Reardon M. D.

Sep 14, 1920 (Address) 352 N. Payson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	Sep 15, 1920
20-UNDERTAKER	ADDRESS
Jno. W. Johnston & Bro	2110 Pulaski

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Moze S. Blank.

D46509

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46509

CERTIFICATE OF DEATH.

145

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses S. Blank

(a) RESIDENCE. NO. 1527 ~~17~~ Ave S. Birmingham, Ala WARD. Birmingham Ala.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male.

4 COLOR OR RACE White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Blank

6 DATE OF BIRTH (month, day, and year) May 20 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) Bavaria
(State or country)

PARENTS

10 NAME OF FATHER Seligman Blank

11 BIRTHPLACE OF FATHER (city or town) Bavaria
(State or country)

12 MAIDEN NAME OF MOTHER Caroline Kramer

13 BIRTHPLACE OF MOTHER (city or town) Saxony
(State or country)

14 Informant Hospital Record J. H. H.
(Address)

15 Filed ....., 19 ..... ROBERT B. BRADHAM
Registrar
SEP 14 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 7 1920 to Sept 10 1920, that I last saw him alive on Sept 7 & 10 1920, and that death occurred, on the date stated above, at 5:10 P.M. a.m.

The CAUSE OF DEATH* was as follows:

Renal insufficiency secondary to carcinoma of prostate.

(duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Prostate

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood urea - Phthalein

(Signed) Howard R. Craig M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Birmingham Ala

DATE OF BURIAL Sept 14 1920

20 UNDERTAKER JOHN F. DENNY

ADDRESS 710 LIGHT ST.

MARGIN RESERVED FOR BINDING—THIS IS A PERMANENT RECORD. Entry must be made in INK. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046570 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046570

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 22 WARD) 117

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Grebliauskiene

(a) RESIDENCE. No. 206 Cypress ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lithuania
(State or country)

PARENTS

10 NAME OF FATHER no

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER no

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Mr. Glyseiski

(Address) 206 Cypress st

15 Filed SEP 14 1920 ROBERT B. FRAZIER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1920, to Sept 13, 1920

that I last saw her alive on Sept 13, 1920

and that death occurred, on the date stated above, at 2.15 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept. 10-20

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Kilpatrick M. D.

, 19 , (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept 15 1920
20 UNDERTAKER	ADDRESS
John Grebliauskas	425 S Paca St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46511 ✓ 8-09 D46511

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1306 Fayette ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruby Hargrove

(Residence in Baltimore: No. 1306 Fayette ave St.; 1 yrs., 7 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, January 31, 1919
(Month) (Day) (Year)

7-AGE, 1 yrs. 7 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Julius Hargrove

11-BIRTHPLACE OF FATHER (State or Country), Georgia

12-MAIDEN NAME OF MOTHER Elena Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Georgia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julsous Hargrove

(Address) 1306 Myrtle ave

15- Filed SEP 14 1920 191.... ROBERT B BRAUER Registrar.

N. B.—Entries must be made in plain terms, as this certificate is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 13th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10th 1920, to Sept 13th 1920, that I saw h[illegible] alive on Sept 13th 1920, and that death occurred, on the date stated above, at 9.40 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Pertussis

(Duration) ....yrs. ....mos. 28 ds.

(Signed) Burwell Fargo M. D.

Sept 14, 1920 (Address) 446 Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Auburn	Sept 14 1920
20-UNDERTAKER John F Owens	ADDRESS 538 Walbert st

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46512

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D46512

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 Cole ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris M. Earley

(a) RESIDENCE. NO. 1531 Cole ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3 1920

7 AGE: Years ... Months 2 Days 11 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... Child

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Samuel K Earley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Lillian Thatcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Samuel K Earley (Address) 1531 Cole St

15 Filed SEP 14 1920 19... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 7th, 1920, to Sept 11th 1920, that I last saw her alive on Sept 11th 1920, and that death occurred, on the date stated above, at 5 30 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion
Decomposition
(duration) about 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. W. Clift, M. D.

9/14. 1920 (Address) Robt Garrett Hosp Dispy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 14 1920

20 UNDERTAKER: John J. Fields ADDRESS: 1200 W Lombard

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

246513

HEALTH DEPARTMENT—CITY OF BALTIMORE

246513

CERTIFICATE OF DEATH.

154

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1258 Riversideave ST.; 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J. Harrison.

(Residence in Baltimore: No. 1258 Riverside Ave St.: ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Dec 26, 1841
(Month) (Day) (Year)

7-AGE, 78 yrs. 8 mos. 15 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): and

9-BIRTHPLACE, (State or Country) Alexandra Va.

PARENTS.

10-NAME OF FATHER, Joerden

11-BIRTHPLACE OF FATHER (State or Country) Alexandra Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew J. Duvall.

(Address) 2717 Alameda Ste

15-

SEP 14 1920

Filed ....., 191.....

ROBERT F. LEADER
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 11, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Sept 11 1920, that I saw h alive on Sept 10 1920, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Infirmities, Old age

(Duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary) Mountain

(Duration) ..... yrs. ..... mos. 11 ds.

(Signed) R. E. Campbell M. D.

Sept 14 1920 (Address) 1644 Division

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cem

DATE OF BURIAL, Sept 14, 1920

20-UNDERTAKER Margaret G. Flynn

ADDRESS 14 & Light Sts

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046514

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046514

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 825 Brooks Lane ST.; 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Madison Smith.

(a) RESIDENCE. No. 825 Brooks Lane ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Anna M. J. Smith

6 DATE OF BIRTH (month, day, and year): Jan. 4-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	76	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Hotel Keeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Anna M. J. Smith

(Address): 825 Brooks Lane

15 Filed SEP 14 1920, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 13. 1920.

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1920, to ~~Sept 13~~, 19~~20~~, that I last saw him alive on Sept 13, 1920 and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Senile Hypertrophy of Prostate Gland

Many years (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pyonephrosis

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 3 1920

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Geo. E. Houck, M. D.

, 19 (Address) 718 W. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodstock Frederick Co Md	Sept 15 1920
20 UNDERTAKER: William Cook	ADDRESS: 502 E North Ave

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

212 W Madison

Spec.—8-24-14—M. & T.—2000 Bks.

D46515 HEALTH DEPARTMENT—CITY OF BALTIMORE D46515

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 129 S. High St. ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Blank

(Residence in Baltimore: No. 129 S. High St. St.; 17 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown, (Month) (Day) 1827 (Year)

7-AGE 93 yrs. mos. ds.

If LESS than 1 day, hrs. or mins.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Balt St

15- SEP 14 1920 ROBERT E FRAUTER

Filed ....., 191.. ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep 14, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sep 10 1920, to Sep 14 1920, that I saw him alive on Sep 14 1920, and that death occurred, on the date stated above, at 10 a m. The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(Duration) yrs. mos. ds.

(Signed) W J Baylin M. D.

9/14, 1920 (Address) 210 Ainsworth

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pikesville Hebrew Cem. DATE OF BURIAL, Sept. 15 1920

20-UNDERTAKER Jack Lewis ADDRESS 1411 E. Balto St

UNFADING INK—THIS IS A PERMANENT RECORD
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1046516 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046516

CERTIFICATE OF DEATH. 169

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1200 Eastern ave ST.: 2 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Nelewski

(Residence in Baltimore: No. 813 Dolphin st St.: yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept 18, 1914 (Month) (Day) (Year)

7-AGE, 5 yrs. 11 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Nelewski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Bolbina Krieger

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Nelewski

(Address) 813 Dolphin St

15- SEP 14 1920 ROBERT B. KRAUTER

Filed ....., 191.... Registrar.

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., 1920 (Month) 9/13 (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an...Inquest... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said...Inquest... (Inquest, autopsy or inquiry.) find that said deceased came to...death... on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) Chas. Lyon Duffy M. D.

Sept 14 1920 (Address) 1806 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, September 15 1920

20-UNDERTAKER John H. Weber

ADDRESS 1803 Bank St

Missing

#D 46517

...M. & T.—2000 Blks.

046518

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 46518

REGISTERED NO. C.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

TY OF BALTIMORE: (No. 1626 Edmondson St.; 16 WARD)

2-FULL NAME Charles H. Riley

esidence in Baltimore: No. 1626 Edmondson a St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

EX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

ATE OF BIRTH, Jan 10, 1920 (Month) (Day) (Year)

GE, ...yrs. 9 mos. 3 ds. | If LESS than 1 day, ...hrs. or.....min.?

CCUPATION:
) Trade, profession, or particular kind of work.....
) General nature of industry, business, or establishment in which employed (or employer).....

RTHPLACE, tate or Country), Baltimore Md.

10-NAME OF FATHER, John H Riley

-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

-MAIDEN NAME OF MOTHER Ella M Lowery

BIRTHPLACE OF MOTHER ate or Country). Baltimore Co

OVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

t)..John H Riley

)..1626 Edmondson Ave

1920 ROBERT J. BRAUNE

191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 13, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 12 1920, to Sept 13 1920, that I saw him alive on Sept 13 1920, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

.....Cholera Infantum.....

..... (Duration).....yrs.....mos. 2 ds.

CONTRIBUTORY (Secondary) Diarrhoea + Toxemia

..... (Duration).....yrs.....mos.....ds.

(Signed) Joseph L. Mayo M. D.

Sept 14, 1920 (Address) 1520 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, 9-14-1920

20-UNDERTAKER Robert Brook & Son

ADDRESS Calhoun Hollins

46519 HEALTH DEPARTMENT—CITY OF BALTIMORE D46519

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 122 W. Ropewalk Lane. ST. 23 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Finney.(C).

(Residence in Baltimore: No. 122 Ropewalk Lane.

40 -------- St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Widow.

6-DATE OF BIRTH, ... Do not know. (Month) ....., 1 (Day) ..... (Year)

7-AGE, 68 yrs. ---------- mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, James Kellum.(C).

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..George Finney.(C).(son)....

(Address).....216 Otterbein Street.

15-

Filed SEP 14 1920, 191... ROBERT P. KRAUSE Registrar of Births

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...September 12th. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart & kidneys.

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos.....ds.

(Signed) H. M. Reinhardt M. D.

Sept. 13 20, 191... (Coroner.) (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Sept 14 1920

20-UNDERTAKER Samuel T. Hendley — ADDRESS 578 W. Pratt

N. B.—Every item of information should be carefully supplied; AGE should be given in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE (Philips)

D46520

CERTIFICATE OF DEATH.

150 D46520

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 Ford Spring Ave. St.; 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Philips

(a) RESIDENCE. No. 226 Ford Spring Ave St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-14-20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	0	1 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER Norman Philips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Banner Co

12 MAIDEN NAME OF MOTHER Hanna Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Norman Philips
(Address) 226 Ford Spring Ave

15 Filed SEP 14 1920, 19.... ROBERT F. CHAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-14 1920

17

I HEREBY CERTIFY, That I attended deceased from 9-14, 1920, to 9-14, 1920

that I last saw h[illegible] alive on 9-14, 1920

and that death occurred, on the date stated above, at 3.9. m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Heart Exam

(Signed) C Lee Houghton, M. D.

9/14, 1920 (Address) 3701 Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Sept 14 1920

20 UNDERTAKER ..... ADDRESS

Cohenouth Son Christmas Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS ... mation should be carefully supplied. AGE should be stated EXACTLY. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D46521 HEALTH DEPARTMENT—CITY OF BALTIMORE D46521

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 813 - Powers St. St.; 13 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin L. Arnold

(Residence in Baltimore: No. 813 Powers St

Sc; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Boy

6-DATE OF BIRTH, Sept 13, 1920
(Month) (Day) (Year)

7-AGE, ... yrs. 5 mos. 5 ds.

If LESS than 1 day, 5 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Balt Md

PARENTS.

10-NAME OF FATHER, Wm E. Arnold

11-BIRTHPLACE OF FATHER (State or Country) Balt Md

12-MAIDEN NAME OF MOTHER, Lelia M. Stump

13-BIRTHPLACE OF MOTHER (State or Country) Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm E. Arnold

(Address) 713 Powers St

15- SEP 14 1920 ROBERT F. KRAUTER

Filed ....., 191.. Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 13, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

Sept 14 1920 (Address) 713 Powers St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden — DATE OF BURIAL, Sept 14 1920

20-UNDERTAKER Chenoweth & Son — ADDRESS Chestnut St

N. B.—Every item of information should be carefully supplied. AGE should be given in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—11 P. Co.—1000 Blks.

1046522

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046522

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3206 [redacted] Baker ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas O. Malcolm

(a) RESIDENCE. NO. 3206 Baker -W ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret M. Malcolm

6 DATE OF BIRTH (month, day, and year) June 8-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Thronton-Rawlings Co.

9 BIRTHPLACE (city or town) (State or country) Sweeden

PARENTS

10 NAME OF FATHER Thomas Malcolm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Christina Eckerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweeden

14 Informant Vincent Malcolm

(Address) 3206 N. Baker St.

15 Filed SEP 14 1920 19 ROBERT B. FRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 . 1920 . to Sept 13 . 1920.

that I last saw him alive on Sept 12, . 1920.

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows: Chr. Int. Nephritis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthma, Dropsy

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Don not known

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Phys. & Urine test

(Signed) E. B. Britton, M. D.

. 19 (Address) 1711 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	9/15/20 19
20 UNDERTAKER	ADDRESS
Chas. F. Evans & Son	Mt. Royal Av

N. B.—WRITE PLAINLY. All information should be carefully supplied. Any CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Isora De Alvarosa Lewis

D. 46523

9-19—H. P. Co.—1000 Bks.

6523

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. Mercy Hospital ST.: 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Mrs Isora Lewis

) RESIDENCE. No. 2559 Edmondson Ave ST.. WARD. 20

(Usual place of abode)

th of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
	W	married

married, widowed, or divorced
HUSBAND of
(or) WIFE of John N. Lewis

TE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	7	7	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)
(State or country) Maryland

10 NAME OF FATHER Charles W. Duckworth

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mahdoma Knight

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant John N. Lewis
(Address) 2559 Edmondson ave

15 Filed SEP 14 1920 Robert P. [illegible]
Registrar

Burial Permit Cl[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 19 20

17 I HEREBY CERTIFY, That I attended deceased from Sept 4 19 20, to Sept 12 19 20

that I last saw h[illegible] alive on Sept 12 19 20

and that death occurred, on the date stated above, at 9.00 P m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

~~Typhoid~~

(duration) yrs. mos. 1 dy

CONTRIBUTORY (Secondary) Typhoid Fever

(duration) yrs. mos. 6 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) J. W. Martindale M. D

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Edmondson Ave Cemetery Westernport Md Philos Cemetery Westernport Md	Sept 15 1920
20 UNDERTAKER	ADDRESS
Geo. Robert & Son	2503 Edmondson ave

D46524 HEALTH DEPARTMENT—CITY OF BALTIMORE D46524

CERTIFICATE OF DEATH.

28

REGISTERED No. C.

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 1630 Mulliken's ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Allen
(Residence in Baltimore: No. 1630 Mulliken St. St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
F.	C-	Married.

6-DATE OF BIRTH: Not known. (Month) , 1 (Day) (Year)

7-AGE 38 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoe Dresser.
(b) General nature of industry, business, or establishment in which employed (or employer): 080

9-BIRTHPLACE, (State or Country)

PARENTS.

10-NAME OF FATHER: Stephen Brown
11-BIRTHPLACE OF FATHER (State or Country): a a Co. Md.
12-MAIDEN NAME OF MOTHER: Rachel Green.
13-BIRTHPLACE OF MOTHER (State or Country): a a Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Stephen Brown
(Address) 630 Madison St.

15- SEP 14 1920 Robert P. Harrison,
Filed ....., 191.... Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Sept. (Month) 12, (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.
The CAUSE OF DEATH* was as follows:
Phthisis Pulmonalis
9
(Duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(Duration) ... yrs. ... mos. ... ds.
(Signed) Wm. H. Blades M. D.
(Coroner.)
9/13/20 (Address) 443 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: ~~Holt~~ Asbury Cem. DATE OF BURIAL: Sept. 15 20

20-UNDERTAKER: Chas. H. Johnson ADDRESS 467 Carlisle Av

N. B.—Every item of information should be carefully supplied. Accurate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

~~D. 30225~~ D. 46525

HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46525

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada Lee

(a) RESIDENCE. NO. 727 Jefferson St ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 22 - 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Simon Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Record
(Address) J. H. H.

15 Filed ... 19 Robert P. Harrison Registrar

SEP 14 1920

Burial Permit Clerk.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1920, to Sept 12, 1920,

that I last saw h.. alive on Sept 12, 1920,

and that death occurred, on the date stated above, at 6[illegible] m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis + Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death? undetermined

Did an operation precede death? No Date of —

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Dr. Hugh J. Georgeson, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Sept 16th 1920
20 UNDERTAKER Chas G Bailey	ADDRESS 421 Fulton St

D46526 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46526

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1115 Hull ST. ST.: 24 WARD) 150

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Sylvester.

(Residence in Baltimore: No. 1115 Hull St. St.; yrs.. mos. 2 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Single.

6-DATE OF BIRTH, September 11th. 1920. / (Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 2 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Sylvester.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER, Anna Wojciechoski.

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Sylvester.(mother)

(Address) 1115 Hull St.

15- Robert P. Harrison,

Filed ....., 191.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 13th. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Congenital.
(Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... da.

(Signed) Wm. Reinhardt M. D.
(Coroner.)
Sep. 13, 20, 191. (Address) 1017 E. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Holy Rosary — DATE OF BURIAL, Sept 14, 20

20-UNDERTAKER Wm Kraskowski — ADDRESS 618 Cavalry Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated [illegible]. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION [illegible] important. See instructions on back of certificate.

SEP 14 1920

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46527 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46527

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH Bay View Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No ..... St.: 26 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Mongela

(a) RESIDENCE. No. Bay View Hosp. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.
12 MAIDEN NAME OF MOTHER Annie Mongela
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Bay View Hosp. (Address) Baltimore, Md.

15 Filed SEPT 14 1920 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9, 1920

17
I HEREBY CERTIFY, That I attended deceased from June 15, 1920, to Sept 9, 1920, that I last saw her alive on Sept 9, 1920, and that death occurred, on the date stated above, at 10:20 P. m.

The CAUSE OF DEATH* was as follows:

Oleo-Colitis (acute)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path. & Clinical findings

(Signed) H. Goldsmith M. D.
9/10/1920 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: SEP 11 1920

20 UNDERTAKER: Commissioner Health. — ADDRESS

Buried [illegible] Permit Clerk]

N. B.—WRITE PLAINLY. ... should be carefully supplied. AGE should be properly classified. ... mation should be carefully supplied. AGE should be properly classified. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.46528

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46528

CERTIFICATE OF DEATH.

151

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2539 Hollins ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Barrett

(Residence in Baltimore: No. 2539 Hollins St

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept (Month) 10 (Day), 1920 (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 1/2 hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Mare
(b) General nature of industry, business, or establishment in which employed (or employer), Ward

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William Barrett

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Elizabeth Hirsch

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Barrett

(Address) 2539 Hollins St

15-

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 10 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1920, to Sept 10 1920, that I saw h[illegible] alive on Sept 10 1920, and that death occurred, on the date stated above, at 11 PM m.

The CAUSE OF DEATH* was as follows:

Premature Birth

5 hrs

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) 0 yrs. 1 mos. 1 ds.

(Signed) Robert C Valentine M. D.

Sept 11, 1920 (Address) 515 Hollins St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ..., 191...

20-UNDERTAKER ADDRESS

JOHNS HOPKINS HOSPITAL

Robert P. Harrison, Commissioner Health.

Per Wm. E. Woodall

SEP 14 1920

SEP 11 1920

N. B.—Every item of information should be carefully noted, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D-46529

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-46529

40

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital. ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Walker.

(a) RESIDENCE. NO. 3002 S. Spring St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Manuel Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10, 1920

17 I HEREBY CERTIFY, That I attended deceased from August 24, 1920, to September 10 1920.

that I last saw him alive on September 10, 1920.

and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 3 ? mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia

& Cachexia (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? not as yet

What test confirmed diagnosis? X-ray + Lab. test.

(Signed) J. A. Holden, M. D.

9/11/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL Sept 14 1920

20 UNDERTAKER Commissioner Health.

ADDRESS

per Wm. F. WOODALL

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be properly classified. Exact CAUSE OF DEATH in plain terms, so that it may be stated on certificates. See instructions on back of certificates. MEDICAL CERTIFICATE OF DEATH is very important.

SEP 14 1920 12:04 Robert P. Harrison, Registrar of Vital Statistics

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46530

D.46530

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-061

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital, Bay View ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Rieck.

(a) RESIDENCE. NO. ? ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Hospital Records.
(Address) City Hospital, Bay View

15 Filed SEP 14 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11, 1920.

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1919, to Sept. 11, 1920, that I last saw h. alive on Sept. 11, 1920, and that death occurred, on the date stated above, at 12 30 A.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis
(no cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Not specialled.

(Signed) R. H. Harrison M. D.

Sept. 12 1920 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	Sept 14 1920
20 UNDERTAKER Commissioner Health,	ADDRESS

Be properly classified. Age should be carefully supplied. Ages should be given in all cases, whether adult or infant. Information should be carefully supplied. Age should be properly classified

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46531

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46531

CERTIFICATE OF DEATH

REGISTERED NO.....

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Preston Apartments ST. 11 WARD) Preston & Guilford Ave

2-FULL NAME Pattie White Jewell

(a) RESIDENCE. No. Preston Apts ST., ... WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 74 yrs 8 mos. 15 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cladius B. Jewell

6 DATE OF BIRTH (month, day, and year) January 28-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Abingdon-
(State or country) Harford Co. Md

PARENTS

10 NAME OF FATHER Thomas White Hall

11 BIRTHPLACE OF FATHER (city or town) Harford Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline A Howard

13 BIRTHPLACE OF MOTHER (city or town) Balls. Co.
(State or country) Maryland

14 Informant Dr. W. S. Hall-
(Address) 215 Woodlawn Road (City)

15 Filed SEP 14 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 1920, to Sept 13, 1920,
that I last saw h[illegible] alive on Sept 13, 1920,
and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) Many yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical signs

(Signed) W. S. Hall, M. D.

Sept 15 1920 (Address) 100 E Caldwell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cemetery- Emmorton- Harford Co. Md.	Sept. 15 1920
20 UNDERTAKER STEWART & MOWEN COMPANY (M. F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated in every case where information can be given. Exact statements should be carefully supplied. AGE should be properly classified. Exact statements of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 46532 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46532

CERTIFICATE OF DEATH. 5 - 45

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. City Hospital, Bay View ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Banks.

(a) RESIDENCE. NO. 138 Calvin St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mns. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Black	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver. 023

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Banks.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Henrietta Pinkett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records (Address) City Hospital, Bay View

15 Filed ..... 19 Robert P. Harrison, Registrar

SEP 14 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-13- 1920

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1920, to Sept 13, 1920, that I last saw him alive on Sept. 13, 1920, and that death occurred, on the date stated above, at 1:45 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(duration) - yrs. 9 mos. - ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray; Wasserman

(Signed) V. B. Hoffman, M. D.

19 (Address) City Hospital, Bay View

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Sept 16 1920
20 UNDERTAKER John W Henderson	ADDRESS 1502 E. Monument

N. B.—WRITE PLAINLY with pen and ink. All information should be carefully supplied. Age, CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D46533

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46533

CERTIFICATE OF DEATH.

151

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3447 Cottage Ave., ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby of Benjaman + Rose Eisenman

(Residence in Baltimore: No. 3447 Cottage Ave., St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept. 13, 1920 (Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work /
(b) General nature of industry, business, or establishment in which employed (or employer) (None)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Benjaman Eisenman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rose Levin

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benjaman Eisenman

(Address) 3447 Cottage Ave.

15- Filed SEP 15 1920, 191.. ROBERT F KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 14, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1920, to Sept 14 1920, that I saw him alive on Sept 13 1920, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
6 months

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs....mos....ds.

(Signed) Jacob Fushan M. D.

Sept 14 1920 (Address) 1823 N. Wash. Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Rosedale — DATE OF BURIAL, Sept. 15, 1920

20-UNDERTAKER Jack Levin — ADDRESS 1411 E. Baltimore St

N. B.—Every item of information should be given if possible. Cause of death may be properly classified only when CAUSE OF DEATH in plain terms, so that it may be understood by the laity, is given. Every item is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 lks.

1046534

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046534

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hotel Rennert ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Mordecai

(a) RESIDENCE. NO. Hotel Rennert ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 11 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced WIFE of (or) ~~HUSBAND of~~ Corinne H. Mordecai

6 DATE OF BIRTH (month, day, and year) July 6 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Charleston South Carolina

PARENTS

10 NAME OF FATHER Benjamin Mordecai

11 BIRTHPLACE OF FATHER (city or town) Charleston (State or country) S.C.

12 MAIDEN NAME OF MOTHER Clara Pollock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Walter C. Mordecai
(Address) New York City

15 Filed SEP 15 1920 ROBERT I. KRAUTER Registrar
Burial Permit Office

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT LOCATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1920.

17

I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1920, to Sept 13th, 1920, that I last saw him alive on Sept 13th, 1920, and that death occurred, on the date stated above, at 8 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.

(duration) yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual symptoms

(Signed) J. A. Chatard, M. D.

, 19 (Address) 40 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Sept 15 1920
20 UNDERTAKER	ADDRESS
Henry W. Justis & Sons Co	Pulaski & Orchard

Spec.—8-24-14—M. & T.—2000 Bks.

1046535

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046535

CERTIFICATE OF DEATH.

104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 575 Dolphin ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Williams

(Residence in Baltimore: No. 575 Dolphin St.; ..... yrs., 6 mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Femal

4-COLOR OR RACE, Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, April ....., 1920
(Month) (Day) (Year)

7-AGE, ... yrs. 5 mos. ..... da.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore md

PARENTS.

10-NAME OF FATHER, Frank Harvey

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Clara Williams

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Harvey

(Address) 575 Dolphin St

15- SEP 15 1920 ROBERT E KRAUTER
Filed ....., 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 7 1920, to Sept 14 1920, that I saw h[illegible] alive on Sept 13 1920, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Acute Paren-Enteritis

..... (Duration) ..... yrs. ..... mos. 7 ..... da.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... da.

(Signed) [illegible] M. D.

Sept 15, 1920 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Sept 15, 1920

20-UNDERTAKER Daniel Easton ADDRESS 916 Pa ave

N. B.—Every item of information should be carefully considered, and CAUSE OF DEATH in plain terms, so that it may be properly classified. All items are important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

2046536 HEALTH DEPARTMENT—CITY OF BALTIMORE 2046536

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 Bolton St.; 14 WARD) REGISTERED NO. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen A Adreon

(Residence in Baltimore: No. 1701 Bolton St.; 74 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	white	married

6-DATE OF BIRTH. May (Month) 27 (Day), 1846 (Year)

7-AGE. 74 yrs. 4 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Grocer
(b) General nature of industry, business, or establishment in which employed (or employer). John D. Mitchell Co.

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Dr John L Adreon

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Winfred Cooper

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mollie E. Adreon

(Address) 1701 Bolton St

15- Filed SEP 15 1920, 191.... ROBERT B KRAUTER Clerk. Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 14 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from June 1st 1920, to Sept 14th 1920, that I saw him alive on Sept 14th 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 2 yrs. mos. ds.

(Signed) H. Lehman M. D.

9-14, 1920. (Address) 211 W. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Sept. 16., 1920.
20-UNDERTAKER	ADDRESS
J C Mitchell	1201 W Fayette St

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Especially important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

1046537

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046537

45

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1324 N Calvert ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Washington Story

(Residence in Baltimore: No. 2324 N Calvert St.; 70 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Jan 5, 1852 (Month) (Day) (Year)

7-AGE, 68 yrs. 8 mos. 9 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Boston

PARENTS.

10-NAME OF FATHER. Isaac Story

11-BIRTHPLACE OF FATHER (State or Country). Mass

12-MAIDEN NAME OF MOTHER. Elizabeth Woodbury

13-BIRTHPLACE OF MOTHER (State or Country), Mass

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Story

(Address) 2324 N Calvert

15-

Filed SEP 15 1920, 191.....

ROBERT B KRAUTER
Burial Permit Registrar

N.B.—Every item of information should be carefully considered, and CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 14, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Sept 14 1920, that I saw h[im] alive on Sept 14 1920, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

(a) Cancer of Pancreas

(Found at Autopsy)

(Duration) yrs. 1½ mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. ..... mos. ..... ds.

(Signed) Wm J Watson M. D.

Sept 17, 1920 (Address) 212 E St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount

DATE OF BURIAL, Sept 16, 1920

20-UNDERTAKER W S Cook

ADDRESS 502 E Wath

Spec.—6-9-19—H. P. Co.—1000 Bks.

0465 38 HEALTH DEPARTMENT—CITY OF BALTIMORE 0465 38

CERTIFICATE OF DEATH. X 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Aliceanna ST.; V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Grabowski

(a) RESIDENCE. NO. 1606 Aliceanna ST., WARD. Mississippi
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of "

6 DATE OF BIRTH (month, day, and year) Dec 13-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Miss

PARENTS

10 NAME OF FATHER Frank Grabowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Antonina Dziuza

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Antonina Grabowski
(Address) 1606 Aliceanna

15 Filed SEP 15 1920 ROBERT F KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 7 1920, to Sept 14 1920, that I last saw h[illegible] alive on Sept 14 11 1920, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) 7 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis (duration) 14 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) William O'Connell M. D.

19 (Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: September 15 1920

20 UNDERTAKER William Fabijanski — ADDRESS [illegible]

mation should be carefully ... at it may be properly ...
CAUSE OF DEATH in plain terms, so that it ...
TION is very important. See instructions on ... of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46539 HEALTH DEPARTMENT—CITY OF BALTIMORE 10·46539

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Balto Gen. Hos. 170 REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Anna Bopst

(a) RESIDENCE. No. 1614 W. Lanvale ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles M. Bopst

6 DATE OF BIRTH (month, day, and year) December 12, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at home.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas C. Richardson

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Christina North

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Charles C. Bopst
(Address) 1614 W. Lanvale St.

15 Filed SEP 15 1920, 19.. BOWEY B KRAUTER Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15th 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1920, to Sept. 15, 1920, that I last saw h[illegible] alive on Sept. 15, 1920, and that death occurred, on the date stated above, at 5.45 A.m.

The CAUSE OF DEATH* was as follows:

Chronic interstial nephritis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood + urine exam.

(Signed) T. C. Dobihal, M. D.

Sept 15, 1920 (Address) S. Balto. Gen Hos.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jos B Cook Western Cem	Sept. 17 1920
20 UNDERTAKER	ADDRESS
1003 W Balto St	1003 W Balto

Inform should be carefully supplied. And it may be properly classified. CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

2046540 HEALTH DEPARTMENT—CITY OF BALTIMORE 2046540

CERTIFICATE OF DEATH.

15 2

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes' Hospital (Street) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hurley

(a) RESIDENCE. No. St. Agnes' Hospital (Street) (Ward)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 13, 1920

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
1 day			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Hurley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Kath. Moran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Lizzie Lehrer

(Address) 320 S. Wilmot St.

15 Filed SEP 15 1920 19 ROBERT F. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 19 20, to Sept 14, 19 20

that I last saw him alive on Sept 14, 19 20

and that death occurred, on the date stated above, at 12:10 a. m.

The CAUSE OF DEATH* was as follows:

Respiratory Failure after prolonged facial presentation & delivery (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) E. P. Greenawalt, M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept 16 1920
20 UNDERTAKER	ADDRESS
John J. Fields	1200 N. Fremont

N. B.—WRITE PLAINLY. All information should be carefully supplied. Any information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 46541 HEALTH DEPARTMENT—CITY OF BALTIMORE D 46541

CERTIFICATE OF DEATH. X 126

1-PLACE OF DEATH Howard A Kelly Hosp. REGISTERED No. C

CITY OF BALTIMORE: (No. 1418 Eutaw Place ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edgar S. Gore,

(Residence in Baltimore: No. Salem Maryland St.; yrs. mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Married

6-DATE OF BIRTH, May (Month) 26 (Day), 1857 (Year)

7-AGE, 63 yrs. 3 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country) Dorchester Co. Md.

PARENTS.

10-NAME OF FATHER, James Gore

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Elizabeth Sewell

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick W. Gore

(Address) Cambridge Md

15-

Filed SEP 15 1920 ROBERT B. CHANLER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH September (Month) 15 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 14 1920, to Sept 15 1920, that I saw him alive on Sept 15 1920, and that death occurred, on the date stated above, at 5-04 A.M.

The CAUSE OF DEATH* was as follows:

Cedema Traumia

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Hypertrophied Prostate Gland

(Duration) yrs. mos. ds.

(Signed) William Reid Jr. M. D.

Sept. 15., 1920 (Address) 1418 Eutaw Place.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Salem Maryland.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hurlock Md	Sept. 17., 1920
20-UNDERTAKER	ADDRESS
Chas. S. Black 742	W. Fort Ave

N.B.—Every item of information should be carefully considered, and the CAUSE OF DEATH in plain terms, so that it may be properly classified. All items are important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D46542

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46542

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Giles

(a) RESIDENCE. NO. Falls Road, Mt. Washington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
42	yrs.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bay View Hosp. reports
(Address)

15 Filed . 19 . Registrar

SEP 15 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1920, to Sept 14, 1920, that I last saw h. alive on Sept 14, 1920, and that death occurred, on the date stated above, at 4:30 P.m.

The CAUSE OF DEATH* was as follows:

Acute Dysentery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) G. C. Medairy, M. D.

. 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Sept. 19 1920
20 UNDERTAKER	ADDRESS
Martin Hughes Son	1827 W N-ave

N. B.—WHITE PAPER. Information should be carefully supplied. All the information should be properly classified, so that it may be CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D46543 HEALTH DEPARTMENT—CITY OF BALTIMORE D46543

CERTIFICATE OF DEATH. X 79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hosp. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Taylor

(a) RESIDENCE. NO. 1133 Woodyear St. ST., WARD. Virginia
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia E. Taylor

6 DATE OF BIRTH (month, day, and year) Aug 23 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38		22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Susan Barker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Record
(Address) J. H. H.

15 Filed ..... 19 .....

SEP 15 1920 ROBERT A. LEGUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14. 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1920, to Sept 14, 1920, that I last saw h.... alive on Sept. 14, 1920, and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) 4 yrs.? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Burgh K Morgan, M. D.

9/14/20 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ditchley Va Northumberland Co Va	Sept 16 1920
20 UNDERTAKER	ADDRESS
Sam W. Chasetson	1700 Madison

MATION should be written in plain terms, so that it may be understood by others than physicians. Use no abbreviations or ditto marks. CAUSE OF DEATH in plain terms, so that it may be understood by others than physicians. Use no abbreviations or ditto marks. TION is very important. See instructions on back of certificates.

McMullan

D46544 HEALTH DEPARTMENT—CITY OF BALTIMORE D46544

104

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1909 N Castle St. 8 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances E. McMillan

(Residence in Baltimore: No. 1909 N Castle St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: M
4-COLOR OR RACE: W.
5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED~~, (Write the word.)

6-DATE OF BIRTH, Jan 17, 20 (Month) (Day) (Year)

7-AGE, 7 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer)?

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.
10-NAME OF FATHER: Chas H. McMillan
11-BIRTHPLACE OF FATHER (State or Country), Balto.
12-MAIDEN NAME OF MOTHER: Laura A Barnes.
13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Anna McMullan
(Address) 1909 N Castle St

15-
Filed SEP 15 1920, 191... ROBERT B LEMMON Registrar. Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 14, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows: Infantile Pickettsis 8 mos. 0 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Geo Edwin Blades M. D. (Coroner) (Address) 443 N Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Sept 16 1920

20-UNDERTAKER George F. Ruth — ADDRESS 1735 Harford Ave.

N. B.—Every item of information should be carefully considered, so that it may be properly classified. Particularly CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 46545

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 D 46545

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 N. Bruce St. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Westly Boston

(a) RESIDENCE. No. 408 N. Bruce St. ST., 19 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Elizabeth Boston

6 DATE OF BIRTH (month, day, and year) Jan. 29, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) Auto. repair shop

(c) Name of employer West End Servace Station

9 BIRTHPLACE (city or town) Easton Md.
(State or country) Tolbert Co

PARENTS

10 NAME OF FATHER Robert Boston

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Dorchester Co. Md.

12 MAIDEN NAME OF MOTHER Emma Boston

13 BIRTHPLACE OF MOTHER (city or town) Trappe
(State or country) Tolbert Co. Md.

14 Informant Mary Boston
(Address) 408 N.Bruce St.

15 Filed ..... 19 .....
Registrar

(Over)

mation should be carefully ... CAUSE OF DEATH in plain terms, so that ... TION is very important. See instructions on ... ...al it may be ... ...s on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/13/1920 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1920, to Sept. 13, 1920, 19, that I last saw h.. alive on Sept. 13th. 1920 19, and that death occurred, on the date stated above, at 4.00 0 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Bilat.

Concussion of the Brain

0731

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Blow on head and right side

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? West End Servace Station

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson M. D.

. 19 (Address) 1618 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Easton Point Tolbert Co Md	SEP 15 1920

20 UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST.

SEP 15 1920 ROBERT E. KRAUTER Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Bks.

D46546 D46546 D46546

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2240 Cambridge ST.; 1 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Keisling

(Residence in Baltimore: No. 2240 Cambridge St.; 1 yrs., 6 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Single

6-DATE OF BIRTH, Feb (Month) 22 (Day), 1919 (Year)

7-AGE, 1 yrs. 6 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Julius Keisling

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Mary Kreisman

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Keisling

(Address) 2240 Cambridge

15-

Filed SEP 15 1920, 191.....

Registrar.

N. B.—Every item of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 15 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 16 1920, to Sept. 15 1920, that I saw h.m alive on Sept 14 1920, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

9/15/20, 191... (Address) ....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
1st German	Sept. 16., 1920

20-UNDERTAKER	ADDRESS
Peter Nicolaus	2046 Eastern

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1046547 50 1046547

1046547

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Obrecht

(a) RESIDENCE. NO. 1114 Madison Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) June 8 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jacob F Obrecht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eleonore Muth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant University Hospital Records

(Address) Lombard & Greene sts.

15 Filed Sept 15 1920 ROBERT E KRAUTER Registrar

SEP 15 1920 Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1920, to Sept 14, 1920, that I last saw h.....alive on Sept. 14, 1920, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

(1) Diabetes Mellitus

(2) Ischio rectal abscess

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 3, 1920

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Cyrus F. Horine, M. D.

, 19 (Address) University Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Sept 16 1920

20 UNDERTAKER John F Denny

ADDRESS 715 Light St

N. B.—WRITE PLAINLY. Information should be carefully supplied, so that it may be properly entered on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly entered on back of certificates. See instructions on back of certificates. TION is very important.

1046548 ✓ 1046548

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1046548

REGISTERED No. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 852 S. Eutaw St. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Edwards.(C)

(Residence in Baltimore: No. 852 S. Eutaw St. St.; yrs., 3 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Single.

6-DATE OF BIRTH, June 11th. 1920., 1 (Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. 2 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Richard Edwards.(C)

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER Arisker Gray.(C)

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arisker Gray.(C) mother.

(Address) 852 S. Eutaw St.

15- ROBERT N. KRAUTER

Filed ..., 191... Registrar.

SEP 15 1920

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 13th. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis.
Malnutrition.
(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) ...
(Duration) ...yrs. ...mos. ...ds.

(Signed) Otto H. C. Reinhardt M. D. (Coroner)

Sep. 14..., 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	SEP 15 1920, 19...
20-UNDERTAKER	ADDRESS

N. B.—Every item of information should be given, so that it may be properly entered. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D465-49 HEALTH DEPARTMENT—CITY OF BALTIMORE D465-49

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 W Hamburg ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Harris

(a) RESIDENCE. No. 415 W Hamburg ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept. 13-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 90 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) 415 W Hamburg St Baltimore Maryland

PARENTS

10 NAME OF FATHER Leroy Bradford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Pearl Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 15 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1920.

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1920, to Sept 13, 1920, that I last saw him alive on Sept 13, 1920, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity
(26 wks premature delivery).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Morris Rucc, M. D.

9-13 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	SEP 15 1920
20 UNDERTAKER	ADDRESS

N. B.—WRITE plainly and with ink. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATTENTION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

1046550 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046550

CERTIFICATE OF DEATH.

50

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 Eason St. ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura A Sparrin

(Residence in Baltimore: No. 1200 Eason St.: 37 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, ... September 9, 1883
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
37 yrs. 4 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Frederick County Md

PARENTS.

10-NAME OF FATHER, Daniel Fretz

11-BIRTHPLACE OF FATHER (State or Country), Frederick County Md

12-MAIDEN NAME OF MOTHER — — —

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Charles Sparrin

(Address)..1200 Eason st.....

15- Filed SEP 15 1920 191.... ROBERT B BRAUTER Registrar.

Burial Permit

N. B.—CAUSE OF DEATH in plain terms. Technical terms unnecessary. Be particular and answer every question. All items important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 14 1920, to Sept 13 1920, that I saw her alive on Sept 13 1920, and that death occurred, on the date stated above, at 11 20 a.m.

The CAUSE OF DEATH* was as follows:

..... Diabetes Mellitus .....

.....

.....

..... (Duration)....yrs....3....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration)....yrs.....mos.....ds.

(Signed)...John A. Arens.....M. D.

....., 191... (Address) 1403 E Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Green Mount Cem	Sept 17, 1920
20-UNDERTAKER	ADDRESS
Rendall Lippit & Son	37 E Lanvale

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46551

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 46551

104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2537 Florence St. 13 WARD)

2-FULL NAME Thomas Hicks

(a) RESIDENCE. NO. 2537 Florence St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 10-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Hicks

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Burton

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant John Hicks (Address) 2537 Florence St

15 Filed SEP 15 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11th 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 3, 1920, to Sept 11, 1920, that I last saw h[illegible]live on Sept 11, 1920, and that death occurred, on the date stated above, at 5 P.M. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. C. Davison, M. D.

19 (Address) John Hopkins Hospital Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 13 1920
20 UNDERTAKER	ADDRESS
Edw. Pinggold	1463 Pacy St

Before filling out this certificate, read carefully the instructions on back of certificates. CAUSE OF DEATH in plain (not technical) terms, so that a layman can understand. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46552 ✓ D.46552

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST.: WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin L. Brown

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? 14 yrs. 3 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
33	yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bay View Hosp. records
(Address)

15 Filed SEP 15 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1920, to Sept 12, 1920, that I last saw him alive on Sept 12, 1920 and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Lues

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy findings

(Signed) Geo. C. Medairy M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 15 1920
20 UNDERTAKER	ADDRESS
Edw. Ringgold.	1463 N. Carey

mation should be given in answering these questions. Write plainly with ink. Do not use abbreviations or initials. CAUSE OF DEATH in plain terms, so that it may be understood by the laity. Do not return to undertaker. Fill out and return to Registrar of Vital Statistics. Failure to make complete return of certificates. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46553 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46553

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1530 mount ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernestine Briant.

(a) RESIDENCE. No. 1530 mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 11 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant - ss

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Jerome Briant

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Susie Gray

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Jerome Briant
(Address) 1530 Mount St

15 Filed SEP 15 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that a non-medical person can understand it. See instructions on back of certificates. MEDICAL CERTIFICATE OF DEATH is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 19 20

17

I HEREBY CERTIFY, That I attended deceased from Sept 11, 19 20 to Sept 13, 19 20

that I last saw h[illegible] alive on Sept 13, 19 20

and that death occurred, on the date stated above, at 7:20 a. m.

The CAUSE OF DEATH* was as follows:

Stenosis X
Broncal Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) pneumonia mak Hem

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1530 mount St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. H. Wiemuth M. D.

, 19 (Address) 708 Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 15 1920
20 UNDERTAKER	ADDRESS
Edw. Ruggold	1463 Carey St

Spec.—8-24-14—M. & T.—2000 Blks.

D.46554 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46554

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1626 Miller ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha A. Harris

(Residence in Baltimore: No. 1626 Miller St.; all her life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~, (*Write* the word.)

6-DATE OF BIRTH, Sept (Month) ....., (Day) 1862 (Year)

7-AGE, 58 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) D3

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Dont know

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo L Harris

(Address) 1626 Miller St

15- Filed SEP 15 1920, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 13 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1920, to Sept 13 1920, that I saw her alive on Sept 13 1920, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. 10 hours mos. ..... ds.

CONTRIBUTORY (Secondary) Coma

..... (Duration) ..... yrs. 10 hours mos. ..... ds.

(Signed) W A Cage M. D.

9/15/20 191... (Address) 707 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL.
Mt. Auburn	Sept. 16., 1920
20-UNDERTAKER	ADDRESS
Thos J. S. Locke	1302 Jefferson

CAUSE OF DEATH in plain terms. important. See instructions on back of certificate.

D.46555 HEALTH DEPARTMENT—CITY OF BALTIMORE. D.46555

CERTIFICATE OF DEATH.

REGISTERED NO. C. 29

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2529 Fairmount Av. (St.) 9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Amalia C Abell

(Residence in Baltimore: No. 2529 Fairmount Av. St.; yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. June 7, 1845 (Month) (Day) (Year)

7-AGE. 75 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Benj Barbour

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Susan E. Whittle

13-BIRTHPLACE OF MOTHER (State or Country). Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marion Dampley

(Address) 2529 Freemont Ave

15- SEP 15 1920 Filed, 191. Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 14, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to *her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(Duration) yrs. mos. ds.

(Signed) Geo Linton Bladen M. D. (Coroner)

9/14/20 191... (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. London Park. DATE OF BURIAL. Sept 16, 1920

20-UNDERTAKER William Cook. ADDRESS 502 E. North Ave

N. B.—Every item of information called for is important, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.46556 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46556

154

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 578 E. Twentieth ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Jane Angel

(Residence in Baltimore: No. 578 E. Twentieth St. St.; 87 yrs., 4 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, May (Month) 3 (Day), 1833 (Year)

7-AGE, 87 yrs. 4 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore. Md

PARENTS.

10-NAME OF FATHER, John Holbrooke

11-BIRTHPLACE OF FATHER (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER Margaret Holbrooke

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Barbara Angel

(Address) 578 E. 20th St. Baltimore

15- SEP 15 1920 Robert P. Harrison, Registrar.
Filed....., 191.....
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 14 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 29 1920, to Sept. 14 1920, that I saw her alive on Sept. 9 1920, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Infirmities of Old Age

.....

..... (Secondary) Senile yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion from ..... (Duration) Senile yrs. ds.

(Signed) Frances A. Carpenter M. D.

Sept. 15, 1920. (Address) 210 Nelson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto	Sept. 17, 1920
20-UNDERTAKER J. N. Cook	ADDRESS 502 E. Madison

CAUSE OF DEATH in plain terms. Omissions important. See instructions on back of certificate.

D.46557 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46557

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Maryland General Hospital St.; 4 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mathilda E. Kemp.

(Residence in Baltimore: No. 653 N. Lexington St; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	Widow

6-DATE OF BIRTH, Dec 31, 1919
(Month) (Day) (Year)

7-AGE, ...yrs. 9 mos. .....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Thurmont Md

PARENTS.

10-NAME OF FATHER. Thomas Kemp

11-BIRTHPLACE OF FATHER (State or Country). Balto

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Bertha Kemp
(Address) 653 N. Lexington

15-
Filed....., 191.....
Registrar.

SEP 15 1920 Robert P. Harrison, Burial Permit Clerk

N. B.—Every item of information must be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.)
find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration).....yrs.....mos. 7 ds.

CONTRIBUTORY (Secondary) no history

(Duration).....yrs.....mos.....ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)
Sept. 15, 1920 (Address) 502 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos. 1 ds. In the State.....yrs.....mos. 1 ds.
Md. Gen. Hosp.
Where was disease contracted, if not at place of death?.....
Former or usual residence 653 N. Lexington St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon	Sept 16, 1920
20-UNDERTAKER Lenhook	ADDRESS 502 E Balto

1946558 HEALTH DEPARTMENT—CITY OF BALTIMORE 1946558

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2806 N Paca St. 6 WARD)

REGISTERED No. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph L. Katzenberger

(Residence in Baltimore: No. 1055 N. Milton Ave St.; yrs. 59 mos. 6 ds. 23)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb 21, 1861 (Month) (Day) (Year)

7-AGE, 59 yrs. 6 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Iron Founder
(b) General nature of industry, business, or establishment in which employed (or employer) Foundry

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER Martin Katzenberger

11-BIRTHPLACE OF FATHER (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), " " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos C. Jr. Katzenberger

(Address) 1055 N. Milton ave

15- SEP 16 1920 ROBERT B KRAUTER

Filed ....., 191.... Registrar.

Burial Permit Given

N.B.—Every item of information should be given in plain terms, so that it may be properly understood. CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 17, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and made a personal or inquiry thereon and from the evidence obtained by said Inquest and inquiry, find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Arteriosclerosis

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) John H. Morrison M. D. Coroner.

Dated this 20 day of Sept, 1920 (Address) 532 Roland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL, Sept 17, 1920

20-UNDERTAKER Henry Hoerle & Son — ADDRESS 120 E Eager St

Spec. 6-9-19—H. P. Co.—1000 Bks.

D46559

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46559

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss May Myers

(a) RESIDENCE. NO. 1908 Lincoln Ave ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Lady.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hutzler Bros Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER ~~Southern~~ Abraham Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Southern

12 MAIDEN NAME OF MOTHER Caroline Hilgeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ~~Southern~~ Baltimore Md

14 Informant ... Johns Lion

(Address) 2529 Brookfield Ave

15 Filed SEP 16 1920 ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14th 1920

17 I HEREBY CERTIFY, That I attended deceased from 8-27, 1920, to 9-14, 1920, that I last saw her alive on 9-14, 1920, and that death occurred, on the date stated above, at 8.10 p m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Uterus

(duration) 1 yrs. 0 mos. ... ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

(duration) ... yrs. ... mos. 3 hrs. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9-7-20

Was there an autopsy? No

What test confirmed diagnosis? Clinical observation

(Signed) Enoch H Adams, M. D.

. 19 (Address) St Agnes Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harrisina Ten	Sept 16 1920
20 UNDERTAKER	ADDRESS
J. Ahrens & Co	1011 Mad Ave

mation sho... CAUSE ... TION is very important. ... instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

2046560 (2046560) 1046560

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harold Foster

(a) RESIDENCE. No. 2943 Henderson St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Five mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harold Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Minnesota

12 MAIDEN NAME OF MOTHER Louise Mafer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record
(Address) J. H. H.

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 4, 1920, to Sept 6, 1920, that I last saw h alive on Sept 4, 1920, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) ....yrs. ....mos. 20 ds.

CONTRIBUTORY (Secondary) None

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? ....Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hector Caspare, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Sept 17 1920
20 UNDERTAKER	ADDRESS
H. Sander Sons	1210 Fleet St

mation shown on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be correctly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046561

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046561

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 S. Ellwood Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret M. Mairose

(a) RESIDENCE. NO. 1102 S. Ellwood Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Walter F. Mairose

11 BIRTHPLACE OF FATHER (city or town) Middle River
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Wandby

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Walter F. Mairose
(Address) 1102 S. Ellwood Ave

15 Filed SEP 16 1920 ROBERT F. KRAUTER Registrar

Burial Permit Oiv'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1920

17 I HEREBY CERTIFY, That I attended deceased from 9 6, 1920, to 9 15, 1920,
that I last saw h[illegible] alive on 9 15, 1920,
and that death occurred, on the date stated above, at 9 45 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) H B Litlow M. D.

9/21, 1920 (Address) 395 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem.	Sept 16 1920
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Fleet St

CAUSE OF DEATH in plain [illegible] TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

0 46562 — 90 D 46562

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2118 Bolton St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Elizabeth Magruder

(Residence in Baltimore: No. 2118 Bolton St.; 70 yrs., ... mos. ... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, ... Feb (Month) 10 (Day), 1860 (Year)

7-AGE, 60 yrs. 7 mos. 4 da.

If LESS than 1 day, ... hrs. or ... min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nothing
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Scotland

PARENTS.

10-NAME OF FATHER, Elafendra Taggart

11-BIRTHPLACE OF FATHER (State or Country) Scotland

12-MAIDEN NAME OF MOTHER, Martha Crawford

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oliver Magruder

(Address) 2118 Bolton St

15-

SEP 16 1920 ROBERT B KRAUTER

Filed ..... 191.....

Burial Permit Clerk

Registrar.

CAUSE OF DEATH. Physicians are required to report the cause of death as directly as possible, and in technical terms. Indefinite and unscientific terms are misleading and unsatisfactory. It is important that the Medical Certificate of Death should be made out in full for every case. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 14 (Day), 1920 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct 1 1918, to Sept 14 1920, that I saw her alive on Sept 14/20, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH was as follows:

Chronic Bronchitis

(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) Pediculosis Pubis

(Duration) ... yrs. ... mos. 2 1 da.

(Signed) Dr C Hamilton M. D.

Sept 15 1920 (Address) 1914 Linden Ave

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn — DATE OF BURIAL, Sept 17, 1920

20-UNDERTAKER, Josiah Lepper & Son — ADDRESS 1600 North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1946563 — 1946563

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Agnes Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Margaret Cremen

(a) RESIDENCE. NO. Washington D.C. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Not any

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Cremen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant St. Agnes Hospital

(Address) Baltimore Md

15 Filed SEP 16 1920 19— ROBERT E. SLATTERY Registrar

Burial Permit Sent

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1918, to Sept 15, 1920 that I last saw he alive on Sept 15, 1920 and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

(duration) 1 yrs. 11 mos. 28 ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. M. K. Craig, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C.

DATE OF BURIAL Sept 16 1920.

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH. See instructions on back. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Blks.

046564

HEALTH DEPARTMENT—CITY OF BALTIMORE

046564

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Liberty Heights Ave (ST.) 15 (WARD) opp. Forest Park

2-FULL NAME William Janney Halliday

(a) RESIDENCE. NO. Liberty Heights Ave ST. 27 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? 72 yrs. 2 mos. 16 ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine B. Halliday

6 DATE OF BIRTH (month, day, and year) June 30, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist

(b) General nature of industry, business, or establishment in which employed (or employer) Owner & Manager

(c) Name of employer - (Self.)

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Robert Halliday

11 BIRTHPLACE OF FATHER (city or town) Dumfries (State or country) Scotland

12 MAIDEN NAME OF MOTHER Jane Lyons

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Miss Sarah C. Crowe (Address) Liberty Heights Ave

15 Filed SEP 16 1920 ROBERT E. [illegible] Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1920, to Sept 15, 1920, that I last saw him alive on Sept 15, 1920, and that death occurred, on the date stated above, at 6:00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 5(?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) — yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? at Place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) William B Dalton, M. D.

9/15. 1920 (Address) 817 Park Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Sept 1920

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Information should be carefully supplied, so that it may be property classified. CAUSE OF DEATH in plain terms, so that it may be readily understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 46565 HEALTH DEPARTMENT—CITY OF BALTIMORE D 46565

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. St.: 3 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kopple Kaplan

(a) RESIDENCE. No. 1328 S. Caroline St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER David Kaplan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Sarah Pozwolla

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Hospital Records

15 Filed SEP 16 1920 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/15 1920

17

I HEREBY CERTIFY, That I attended deceased from 9/7 1920, to 9/15 1920, that I last saw h[illegible] alive on 9/15 1920, and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Chronic Malnutrition

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Irma L. Ridgely, M. D.

(Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt. Carmel — DATE OF BURIAL: Sept 16 192[illegible]

20 UNDERTAKER: Jack Lewis — ADDRESS: 1411 E. Balto

CAUSE OF DEATH must be plainly written. See instructions on back of certificate. TION is very important.

Spec.—5-19-13—M. & T.—500 Bks.

1046566

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046566

CERTIFICATE OF DEATH.

170

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1) Falls Rd (Mt Wash) ST.; 27 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret D Kauffman Mill

(Residence in Baltimore: No. Falls Rd St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widowed

6-DATE OF BIRTH, August 11, 1866 (Month) (Day) (Year)

7-AGE, 54 yrs. 1 mos. 0 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... none

9-BIRTHPLACE, (State or Country) Washington Borough Lancaster Co Pa

PARENTS.

10-NAME OF FATHER, David R. Taylor

11-BIRTHPLACE OF FATHER (State or Country), Lancaster Co Pa

12-MAIDEN NAME OF MOTHER Anna Elizabeth Keen

13-BIRTHPLACE OF MOTHER (State or Country), Penn Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W K Taylor

(Address) Lancaster Pa

15- SEP 16 1920 ROBERT E KRAUTER

Filed ....., 191.... Registrar.

CAUSE OF DEATH. See instructions on back of certificate. Important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 14, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Sept 14 1920, that I saw her alive on Sept 14 1920, and that death occurred, on the date stated above, at 9.15 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(Duration) 1 yrs. 4 mos. 3 ds.

(Signed) William L Ford M. D.

9.15, 1920 (Address) Washington 24th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cem — DATE OF BURIAL, Sept 17, 1920

20-UNDERTAKER Henry W Jenkins Sons Co — ADDRESS Fulton & Orchard

Spec.—6-9-19—H. P. Co.—1000 Bks.

1420 46567

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1420 46567

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospt. ST.: 426 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Doroshchuk.

(a) RESIDENCE. No. Bay View Hospital ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record
(Address) J. H. H.

15 Filed SEP 16 1920 ROBERT P. LAMDIN
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1920, to Sept 14, 1920, that I last saw him alive on Sept 14, 1920, and that death occurred, on the date stated above, at 8 22 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/11/20

Was there an autopsy? yes

What test confirmed diagnosis? Examination of lungs

(Signed) H. H. Carter, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Swartz Cem	Sept 17 1920
20 UNDERTAKER	ADDRESS
Stephen J. Kwalkowski	1005 Hanover

CAUSE OF DEATH in plain terms, as directed on back of certificate. TION is very important. See instructions on back of certificate.

D46568 HEALTH DEPARTMENT—CITY OF BALTIMORE D46568

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1330 N. Stricker St. 15 WARD) 45

REGISTERED No. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joshua J. Barnett

(Residence in Baltimore: No. 1330 N. Stricker St. St.: 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	colored	widower

6-DATE OF BIRTH, April 20, 1849
(Month) (Day) (Year)

7-AGE, 71 yrs. mos. 24 da.

If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ethel Carter

(Address) 1330 N. Stricker

15- SEP 16 1920 BOBERT B KRAUTHE

Filed....., 191.. ..... Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest~~ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma (Chest) (Breast both) (Breasts)

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) ~~Cause~~ History

(Duration) yrs. mos. ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)

Sept 15, 1920 (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Int Auburn Cem	Sept 16, 1920
20-UNDERTAKER	ADDRESS
George H. Boltz	1631 Aisquith

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46569 — D46569 — Hampstead Pa. — 45

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Magnolia ave & Argyle ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Lang

(a) RESIDENCE. No. Magnolia Ave & Argyle ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Lang

6 DATE OF BIRTH (month, day, and year) July 6th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber Supplies

(b) General nature of industry, business, or establishment in which employed (or employer) 421 W Pratt St

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Lang

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Lang (Address) Magnolia & Argyle Sts

15 Filed SEP 16 1920 19 ROBERT J. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15/20 19

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to Sept 15, 1920, that I last saw h[illegible] alive on Sept 15, 1920, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Throat

(duration) 4 yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of June 9/20

Was there an autopsy? No

What test confirmed diagnosis? Diagnosed.

(Signed) Wales Hurd M. D.

9/16, 1920 (Address) Arlington.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Sept 17/20
20 UNDERTAKER	ADDRESS
G. B. Hoppert	2216 Fred'k Ave

CAUSE OF DEATH must be given in full by physician. INFORMATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46570

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46570

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1403 Penna ave Lift 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jas Delrow

(a) RESIDENCE. No. 1403 Penna av ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	B	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X.

6 DATE OF BIRTH (month, day, and year) Sept 12 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	X.	X	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work X.

(b) General nature of Industry, business, or establishment in which employed (or employer) X

(c) Name of employer X

9 BIRTHPLACE (city or town) (State or country) 1403 Penna av Md

PARENTS

10 NAME OF FATHER Ashbury Delrow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va Va

12 MAIDEN NAME OF MOTHER Rose Carlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S C

14 Informant (Address) Mother

15 Filed SEP 16 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1920, to Sept 15, 1920, that I last saw him alive on Sept 14, 1920, and that death occurred, on the date stated above, at 7.9 m.

The CAUSE OF DEATH* was as follows:

Exhaustion
7 mo Pregnancy
of Mother

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 2 Hours of Mother
8 Weeks (duration) yrs. mos. ds.

13 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X

(Signed) John B Mangan, M. D.

, 19 (Address) 1002 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St Peters Cem SEP 16 1920

20 UNDERTAKER — ADDRESS

Edw P Ringgold 1463 N Carey

CAUSE OF DEATH. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

046571

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 046571

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 Gorsuch Ave. St.: 9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Bertling

(a) RESIDENCE. No. 1120 Gorsuch Ave St., Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Bertling

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Home Work

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Brickwatte

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Bernard J Bertling

(Address) 1120 Gorsuch Ave

15 Filed SEP 16 1920 ROBERT P. KRAUTER Registrar

Burial Permit Given

CAUSE OF DEATH IS very important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15 1920

17

I HEREBY CERTIFY, That I attended deceased from June 3 1919, to Sept 15, 1920,

that I last saw her alive on Sept 7, 1920,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bertha E. Tapman, M. D.

Sept. 15, 1920 (Address) 2733 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross, Brooklin	Sept 18 1920

20 UNDERTAKER H M Routson

ADDRESS 230 N Greene

Spec.—6-9-19—H. P. Co.—1000 Bks.

046572 HEALTH DEPARTMENT—CITY OF BALTIMORE 046572

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 E Eager St. 10 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Rowell Fokler

(a) RESIDENCE. No. 923 E Eager St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 0 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 12, 1920

7 AGE Years	Months	Days	If LESS than I day, hrs. or min.
—	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER George Thomas Fokler

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Mary Bailey

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant
(Address) 923 E Eager St

15 Filed SEP 16 1920 19 ROBERT B. KRAUTH Registrar of Records

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 19 20

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 19 20, to Sept 13, 19 20, that I last saw h alive on Sept 13, 19 20, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Intestinal Decomposition

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. Wm. T. Gott, M. D.

(Address) 27 N Caley St

Sept 15, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept 17 1920
20 UNDERTAKER E W Conklin	ADDRESS 246 Eager

CAUSE OF DEATH must be stated plainly. Every question must be answered. Physician's or Undertaker's Certificate must be filed with Registrar of Records before a burial permit will be issued. Blank must be returned to Registrar of Records within 24 hours after death. Failure to comply with these requirements is a misdemeanor. See instructions on back of certificate. TION is very important.

Spec.—6-5-19—H. P. Co.—1000 Bks.

D46573

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D46573

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 W Franklin ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha R Schoenfelder

(a) RESIDENCE. NO. 1510 W Franklin ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) July 31st 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	24	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Oswald Schoenfelder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Tanzmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Oswald Schoenfelder (Address) 1510 W Franklin St

15 Filed SEP 16 1920 ROBERT F. LEADER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15th 1920

17

I HEREBY CERTIFY, That I attended deceased from March, 1920, to September 15 1920.

that I last saw h.. alive on September 13, 1920,

and that death occurred, on the date stated above, at 7. a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion + Septicemia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Milton P. Hall, M. D.

19 (Address) Wyler an - Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 17 1920
20 UNDERTAKER	ADDRESS 2016
Philip Henry	Orleans

CAUSE OF DEATH must be filled in. See instructions on back of certificate. TION is very important.

D46574 HEALTH DEPARTMENT--CITY OF BALTIMORE D46574

CERTIFICATE OF DEATH

64

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 4116 Frederick Av. St.; 20 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2 FULL NAME John A Wilson

(Residence in Baltimore: No. 4116 Frederick Av. St.; 45 yrs. mos. ds.) in U S

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: May 30, 1860 (Month) (Day) (Year)

7 AGE: 60 yrs. 3 mos. 15 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Stationary Engineer 30
(b) General nature of industry, business, or establishment in which employed (or employer): Furniture Factory

9 BIRTHPLACE (State or country): Sweden

PARENTS

10 NAME OF FATHER: Phillip Wilson

11 BIRTHPLACE OF FATHER (State or country): Sweden

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Sweden

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Julia Wilson

(Address) 4116 Frederick Ave

15 Filed SEP 16 1920 191 ROBERT B BRUTER Registrar

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. 15, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11, 1920 to Sept 15 1920 that I saw h[illegible] alive on Sept 14, 1920 and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Hypertension
Cerebral hemorrhage

(Duration) 2 yrs. 2 mos. 4 ds

Contributory (SECONDARY) 4 attack of ulcers

(Duration) yrs. mos. ds.

(Signed) Gusta Stevens M. D.

Sept 16, 1920 (Address) 7866 Harford Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St Patricks Cem — DATE OF BURIAL: Sept 17, 1920

20 UNDERTAKER: Margaret E Flynn — ADDRESS: 14 W Eight St.

N.B.—Every item of information should be given. Be sure that it may be properly classified. Be sure to state CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46575 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46575

CERTIFICATE OF DEATH. 105

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2133 Vine ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Hardt

(a) RESIDENCE. No. 2133 Vine ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 25 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Hardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margie Rick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) John Hardt 2133 Vine St

15 Filed SEP 16 1920 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-15 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7 1920, to Sept 15 1920, that I last saw him alive on Sept 15 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Arteitis.

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Epilepsy

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Hubert C Blake, M. D.

, 19 (Address) 1014 N Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 12/17 1920

20 UNDERTAKER George H Corley Sulton

ADDRESS Fayette

CAUSE OF DEATH ... TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 46576 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 64 D 46576

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 533 Edmondson Ave ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard. Munter

(a) RESIDENCE. No. 533. Edmondson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Anna L. Munter

6 DATE OF BIRTH (month, day, and year) July 3rd 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	70	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry. Munter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Hoegel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm. H. Munter
(Address) 533 Edmondson Ave

15 Filed . 19 Robert P. Harrison, Registrar

SEP 16 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15th 1920

17 I HEREBY CERTIFY, That I attended deceased from May 10 . 1920 . to Sept 15 . 1920 .

that I last saw him alive on Sep. 15 . 1920 .

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 3 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Physical Signs

What test confirmed diagnosis?

(Signed) H. Masterson, M. D.

9/16 . 1920 Address) 10 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Sept 17th 1920
20 UNDERTAKER	ADDRESS
Graham & Wachow	723 W. Fay

CAUSE OF DEATH. See instructions on back of TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

2046577

HEALTH DEPARTMENT—CITY OF BALTIMORE

2046577

CERTIFICATE OF DEATH.

149

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 625 W. Lee St ST.. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora M. Snyder

(a) RESIDENCE. NO. 625 W. Lee St ST.. 22 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 6 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 17th 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Andrew Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Griese

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Augusta Snyder

(Address) 625 Lee St

15 Filed SEP 16 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to Sept 15, 1920.

that I last saw h.. alive on Sept 14, 1920,

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatism
Pneumonia

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Hammond Lee Jr, M. D.

Sept 15 1920 (Address) 835 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 18 1920
20 UNDERTAKER	ADDRESS 1029
E. Schlosnagle Son	Monument

CAUSE OF DEATH TION is very important. See instructions on back

D.46578 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46578

CERTIFICATE OF DEATH

1-PLACE OF DEATH Mercy Hospital 14 46 REGISTERED NO. C.

CITY OF BALTIMORE (No. ... St.: ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pearl M. Brown

(Residence in Baltimore: No. 1533 Linden Ave. St.: 1 yrs., 4 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F. | 4-COLOR OR RACE, W. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) S.

6-DATE OF BIRTH, May 12 1919
(Month) (Day) (Year)

7-AGE, 1 yrs. 4 mos. 3 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Frank L. Brown

11-BIRTHPLACE OF FATHER (State or Country), Phila Pa

12-MAIDEN NAME OF MOTHER Matilda Poor

13-BIRTHPLACE OF MOTHER (State or Country), Indian Nile N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. L. Brown

(Address) 1532 Linden Ave

15- Filed SEP 16 1920, 191... Registrar.
Robert P. Harrison, Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be understood. Omit abbreviations. Every item important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry,) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc;
Exhaustion
(Duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) ...
(Duration) ... yrs. ... mos. 1 ds.

(Signed) ... M. D.
(Coroner)
101 (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? ...
Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cem	Sept 17 1920
20-UNDERTAKER Kerrigan & Gore	ADDRESS 1735 W Lafayette Ave

D.46579 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46579

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Johns Hopkins Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lizzie Lowman

(Residence in Baltimore: No. Jones Ave Catonsville Md St.: yrs., mos. (1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, Sept 29, 1871 (Month) (Day) (Year)

7-AGE, 48 yrs. 11 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Housework

9-BIRTHPLACE, (State or Country), Carroll Co Md

PARENTS.

10-NAME OF FATHER, Levi E Lowman

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sarah Simpson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James E. Lowman

(Address) 1708 Druid Hill Ave

15- Robert P. Harrison,

SEP 16 1920

Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept 14, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(Duration) yrs. 6 mos. 24 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. mos. ds.

(Signed) Geo Albert Blake M. D. (Coroner.)

9/16/20 191... (Address) 1143 E Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Sykesville Md.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Sykesville Md	Sept 17, 1920

20-UNDERTAKER Geo C. H. Holland ADDRESS 1631 Druid Hill Ave

CAUSE OF DEATH in plain terms. Omissions will delay burial permit. important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.46580

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.46580

CERTIFICATE OF DEATH.

15-79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2101 Allendale Road ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Chesnut

(a) RESIDENCE. NO. 2101 Allendale Road ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. 7 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Cassidy

6 DATE OF BIRTH (month, day, and year) Jan. 17, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Wholesale Grocery Merchant

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Chesnut

11 BIRTHPLACE OF FATHER (city or town) Wilmington
(State or country) Delaware

12 MAIDEN NAME OF MOTHER Ann Eliza Rice

13 BIRTHPLACE OF MOTHER (city or town) Wilmington
(State or country) Delaware

14 Informant Miss Annie Chesnut
(Address) 2101 Allendale Road

15 Filed SEPT 16 1920 19 Robert P. Harrison Registrar

Burial Permit Clerk.

CAUSE OF DEATH. This information is very important. See instructions on back of this sheet.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-14 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1 1920, to Sept 14 1920, that I last saw h[illegible] alive on Sept 13 1920, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. J. McAvoy M. D.

9/15 1920 (Address) 8 E. Eldwordan

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Natnre of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 9/17 1920

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS: 305 N. Calvert

Spec.—8-24-14—M. & T.—2000 Bks.

046581

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 046581

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Mc Henry St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert F Morgan

(Residence in Baltimore: No. 1416 Mc Henry St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, July (Month) 26 (Day) 1920 (Year)

7-AGE, ...yrs. 1 mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Ernest Morgan

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Lillian B. Seeley

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Morgan

(Address) 1416 Mc Henry

15- SEP 17 1920 ROBERT P KRAUTER

Filed....., 191.... Registrar.

important. See instructions on back of

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 15 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 4 1920, to Sept 15 1920, that I saw h alive on Sept 15 1920, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) ....yrs. ....mos. 11 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) ....yrs. ....mos. 3 ds.

(Signed) Herbert F Morgan M. D.

Sept 16 1920. (Address) 215 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Sept 17, 1920

20-UNDERTAKER John J Fields — ADDRESS 1200 W Lombard

1046582 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046582

CERTIFICATE OF DEATH. 79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 673 Pierce ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Stewart

(a) RESIDENCE. NO. 673 Pierce ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Blk	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 16th 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	—	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Viola Coolz. (Address) 673 Pierce st

15 Filed SEP 17 1920, 19 ROBERT F. LEATHERBURY Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1920, to Sept 14, 1920,
that I last saw her alive on Sept 14, 1920,
and that death occurred, on the date stated above, at 1.30 P. m.
The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Anasarca
(duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Gustav Goldman, M. D.
, 19 (Address) 836 W Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 17 1920
20 UNDERTAKER David Easton	ADDRESS 916 Penna ave

CAUSE OF DEATH. See instructions on back. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

046583

HEALTH DEPARTMENT—CITY OF BALTIMORE

146 046583

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST.; WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Davis

(a) RESIDENCE. NO. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
30	yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of Industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Bay View Hospital Records

15 Filed SEP 17 1920, 19 ROBERT E. S[illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 1920

17 I HEREBY CERTIFY, That I attended deceased from August 28 1920, to Sept 13, 1920, that I last saw h[illegible] alive on Sept 13, 1920, and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Infectious Osteomyelitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septic Meningitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical + Laboratory findings

(Signed) E. C. Metzairy, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Sept 17 1920

20 UNDERTAKER: JAMES H. DENNIS — ADDRESS: 1303 PRESTMAN ST.

CAUSE OF DEATH IS VERY IMPORTANT. See instructions on back

Spec. 6-9-19—H. P. Co.—1000 Bks.

1046584 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046584

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1337 Woodyear ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A. Claggett.

(a) RESIDENCE. NO. 1337 Woodyear ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May - 1872

7 AGE	Years	Months	Days	If LESS than 1 day.... hrs. or .... min.
	48	4	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Columbus Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline Lyon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William Campbell
(Address) 863 Vine St.

15 Filed SEP 17 1920 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1920

17 I HEREBY CERTIFY, That I attended deceased from May 25, 19 19. to Sept 15, 19 20.
that I last saw h~~e~~r alive on Sept 13 19 20.
and that death occurred, on the date stated above, at 5:30 A. m.
The CAUSE OF DEATH* was as follows:

Chr. Organic Heart Disease.
Right Hemiplegia
(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James Bogue, M. D.
9/15 1920 (Address) 1837 Seneca Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Star

DATE OF BURIAL Sept 17 1920

20 UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

CAUTION—This certificate is very important. See instructions on back of blank.

ROBERT E. SLATER
Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

Adam Peter Levandowski

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046585

CERTIFICATE OF DEATH.

151046585

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 722 S. Regester St.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Levandowski

(a) RESIDENCE. NO. 722 S Regester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year) Sept 7, 1920.

7 AGE Years: Months: Days: 9. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant, 00

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Infant

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Joseph Levandowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Ora L. Pistant

13 BIRTHPLACE OF MOTHER (city or town) (State or country): South Carolina

14 Informant: Joseph Levandowski
(Address) 722 S Regester St.

15 Filed SEP 16, 1920 ROBERT F. [illegible] Registrar

Burial Permit Oleft

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 11, 1920, to Sept 17, 1920,

that I last saw h— alive on Sept 14, 1920,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: Congenital Weakness

Congenital

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Gastritis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

What test confirmed diagnosis?

(Signed) J. Wenlan, M. D.

(Address) 160 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: 9/17/20 -19

20 UNDERTAKER: Kendall Hopper & Son

ADDRESS: 37 W Lanvale

Spec.—8-24-14—M. & T.—2000 Bks.

0946586 HEALTH DEPARTMENT—CITY OF BALTIMORE 0946586

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 Robert ST.; 14 WARD) REGISTERED NO. C 104

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence A. Johnson, Jr.

(Residence in Baltimore: No. 507 Robert St. St.; / yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, Apr. (Month) 19 (Day), 1920 (Year)

7-AGE, 1 yrs. 5 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Clarence A. Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Ruth Murray

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence A. Johnson

(Address) 507 Robert Street

15- SEP 17 1920 ROBERT F KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 15 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 6 1920, to Sept. 15 1920, that I saw him alive on Sept. 15 1920, and that death occurred, on the date stated above, at 12:00 m.

The CAUSE OF DEATH* was as follows:

Entero - Colitis

3 wks.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(Duration) yrs. mos. ds.

(Signed) C. W. L. Carr M. D.

Sept. 17, 1920 (Address) 515 Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cemetery	Sept. 17, 1920
20-UNDERTAKER Jno. M. Johnson	ADDRESS 1234 Ellin St.

important. See instructions on back.

046587 HEALTH DEPARTMENT—CITY OF BALTIMORE 046587

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2004 W. North ave ST.: 15 WARD) — 64

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Shapiro

(Residence in Baltimore: No. 2004 W. North ave St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1850 (Year)

7-AGE, 70 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Iron & Metal
(b) General nature of industry, business, or establishment in which employed (or employer): Dealer

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Issac Shapiro

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jake Shapiro

(Address) 17[illegible] N. Fulton

15- SEP 17 1920 ROBERT E KRAUTER
Filed ....., 191.... Registrar.
Burial Permit Issued

CAUSE OF DEATH in plain terms. Omissions important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 15, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(Duration) 1 yrs. ....mos. ....ds.

(Signed) J. F. Hennessy (Coroner) M. D.

Sept 16, 1920 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel — DATE OF BURIAL, Sept. 17, 1920

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E. Baltimore

Spec.—6-9-19—H. P. Co.—1000 Blks.

046588

HEALTH DEPARTMENT—CITY OF BALTIMORE

120 046588

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 413 N. Mount St. ST.: 19 WARD)

2-FULL NAME Martha Thomas

(a) RESIDENCE. No. 413 N. Mount ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
30				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Pvt

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER Richard Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dolly Blake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James Gross
(Address) 818 Woodyear

15 Filed SEP 17 1920 19 ROBERT 5 FAULTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 11 1920 to Sept 14 1920

that I last saw her alive on Sept 14 1920

and that death occurred, on the date stated above, at 4. P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Chronic Bright Disease

(duration) 15 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Bright Disease

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lee W Kennard M. D.

Sept. 15 1920 (Address) 705 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 17 1920
20 UNDERTAKER	ADDRESS
Sam'l. Chase & Son	1400 Madison

TION is very important. See instructions on

Spec.—6-9-19—H. F. Co.—1000 Bks.

1946589 HEALTH DEPARTMENT—CITY OF BALTIMORE 1946589

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 527 N Robinson ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Wells

(a) RESIDENCE. NO. 527 N Robinson ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work no 000

(b) General nature of industry, business, or establishment in which employed (or employer) no

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Walter M. Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Atlanta Ga.

12 MAIDEN NAME OF MOTHER Elizabeth Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Atlanta Ga.

14 Informant Walter M. Wells.
(Address) 527 N Robinson St

15 Filed SEP 17 1920 19 BURIAL PERMIT Registrar
Burial Permit 01627

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 12 (12) 19 20 to Sept 16 19 20

that I last saw h e alive on Sept 15 19 20

and that death occurred, on the date stated above, at 8 am m.

The CAUSE OF DEATH* was as follows:

Manslaughter
(Rupt. Pancreas)

Ileo Colitis (duration) yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Enteric Cholitis

0 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. J. Riley, M. D.

. 19 (Address) 1654 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Sept 17 1920
20 UNDERTAKER Robt J. Turner	ADDRESS 1442 Bway

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46590

CERTIFICATE OF DEATH.

151 D 46590

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Della Noce

(a) RESIDENCE. NO. 329 Twenty Fourth ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15, 1920.

7 AGE Years Months Days: 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of indostry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Della Noce

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Victoria Grue

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Frank Della Noce
(Address) 329 E 24th St

15 Filed SEP 17 1920, 19 ROBERT B. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16, 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1920, to Sept. 16, 1920,

that I last saw her alive on Sept 16, 1920,

and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J B Bromwhas, M. D.

9-17-1920 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Sept 17 1920

20 UNDERTAKER: J Herwig & Co

ADDRESS: 2108 Eastern

CAUSE OF DEATH. See INSTRUCTION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46591 ✓ D46591

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5008 Tioga ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Elizabeth Thistel

(a) RESIDENCE. NO. 5008 Tioga ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 12 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Carl. H Thistel

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Augusta Schmidt

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Carl. H. Thistel
(Address) 5008 Tioga Ave.

15 Filed ... 19 ... Registrar

SEP 17 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15 1920

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1920, to Sept. 15, 1920, that I last saw her alive on Sept. 15, 1920, and that death occurred, on the date stated above, at 11.40 P. m.

The CAUSE OF DEATH* was as follows:

Ileo. Colitis.

(duration) ... yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. C. Haer, M. D.

. 19 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wood Lawn Cem	Sept 17th 1920
20 UNDERTAKER	ADDRESS
Leo. G. Cook	Northwood Md

CAUSE OF DEATH ... TION is very important. See instructions on back

1046592 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046592

CERTIFICATE OF DEATH. 8 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1729 N. Chester St., 17 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fib. Edward Ruehl.

(Residence in Baltimore: No. 1729 N. Chester. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. June (Month) 17 (Day) 1878 (Year)

7-AGE. 42 yrs. 2 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Packer
(b) General nature of industry, business, or establishment in which employed (or employer). Lithographer Printing Co

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Edward Ruhl

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Emily Smack

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Lucy A. Ruhl

(Address) 1729 No. Chester St.

15-

Filed SEP 17 1920, 191.... ROBERT B. KLAUTER Registrar.

CAUSE OF DEATH to please write important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Aortic Stenosis

(Duration ... yrs. ... mos. ... ds.)

CONTRIBUTORY (Secondary) Aortic Stenosis

(Duration ... yrs. ... mos. ... ds.)

(Signed) G. C. Blades M. D.
(Coroner.)

9/16/20 (Address) 1436 Bway

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem	Sept 18 20
20-UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Bell St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

046593 — 79 046593.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Little Sisters of the Poor — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 1 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Ellwood

(Residence in Baltimore: No. Formally 1115 Binney St. St.; 50 yrs.. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1858 (Year)

7-AGE.	If LESS than 1 day,
62 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thomas Ellwood

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Anne Bannan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15-

Filed SEP 17 1920, 191.....

ROBERT F. BRAUER
BURIAL PERMIT CLERK
Registrar

important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 15th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I saw h[im] alive on Sept 12 1920,
and that death occurred, on the date stated above, at 5 8 m.
The CAUSE OF DEATH* was as follows:

Valvular Disease of heart
Unknown (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Dropsy
..... (Duration).....yrs.....mos.....ds.

(Signed) L. A. Warner M. D.
Sept. 15 191... (Address) 1132 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death 3 yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residance .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	Sept. 18th, 1920
20-UNDERTAKER	**ADDRESS**
Lilly & Zeller	403 N. Wolfe St

Spec.—6-9-19—H. P. Co.—1000 Bks.

9 Keys.

D 46594 HEALTH DEPARTMENT—CITY OF BALTIMORE D 46594

CERTIFICATE OF DEATH.

H 1 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Keys

(a) RESIDENCE. NO. 961 N. Gay St. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. W. M. Keys

6 DATE OF BIRTH (month, day, and year) May 10, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm F. Keys

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Isabelle McKenzie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Rosa M. Keys

(Address) 961 N. Gay St.

15 Filed SEP 17 1920 ROBERT E. LEATHERBURY Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1920, to Sept 16, 1920, that I last saw him alive on Sept. 16, 1920, and that death occurred, on the date stated above, at 10.27a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug. 22.

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Louis D. Rodgers, M. D.

9/16, 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept. 20 1920

20 UNDERTAKER Wm. E. Black ADDRESS 927 N. Broadway

CAUSE OF DEATH SHOULD BE FILLED IN BY PHYSICIAN. ATTENTION is very important. See instructions on back.

2919 E Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46595 HEALTH DEPARTMENT—CITY OF BALTIMORE D46595

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 N 8th St. Highland Town Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Edna Haase

(a) RESIDENCE. No. 1124 N 8th St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced (write the word)~~: Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20 1920

7 AGE: Years 2 Months Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: William Haase

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Blackford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: William Haase
(Address): 1124 N 8th St

15 Filed SEP 17 1920 19 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1920

17 I HEREBY CERTIFY, That I attended deceased from 9/15/20 19, to 9/16/20 19, that I last saw her alive on 9/16/20, 19, and that death occurred, on the date stated above, at 12. 10 P.M.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical dx

(Signed) F. H Herrman M. D.

(Address) 2919 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem — DATE OF BURIAL: Sept 18 1920

20 UNDERTAKER: J Kreuzer & Co — ADDRESS: 2008 Eden

IMPORTANT. See instructions on back. ATION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 1946596

1946596

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2213 Roslyn Ave St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Franz Joseph Siegel

(Residence in Baltimore: No. 2213 Roslyn ave, St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, July (Month) 28 (Day), 1841 (Year)

7-AGE, 79 yrs. 1 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work Retired 045 (b) General nature of industry, business, or establishment in which employed (or employer) Merchant

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. Charles Siegel

(Address) 2213 Roslyn Ave

15- Filed SEP 17 1920 191.....

ROBERT E KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 16 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 7 1920, to Sept 16 1920, that I saw him alive on Sept 15 1920, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. 1 mos. 9 ds.

Arteriosclerosis

CONTRIBUTORY (Secondary) Unknown (Duration) ..... yrs. ..... mos. ..... ds.

E H Mottor M. D.

(Signed) .....

Sep 16, 1920. (Address) 1711 E Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, ~~Holy Redeemer~~ London Park DATE OF BURIAL. Sept 17 1920

20-UNDERTAKER J Herzog & Co ADDRESS 2008 Albans

Important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

143063 D.46597 D.46597

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. St.: 3 2th WARD)

2-FULL NAME Harry Cohen

(a) RESIDENCE. NO. 15 D High Street ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Hyman Cohen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Fanny Karp.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Hospital Record
(Address) J. Hopk.

15 Filed SEP 17 1920 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7 - 1920, to Sept 13 1920, that I last saw h.. alive on Sept. 13 1920, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm C Davison, M. D.

, 19 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cemetery	Sept. 17 1920
20 UNDERTAKER Jack Lewis, 1411 E.	ADDRESS Balto. Md

TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0.46598

HEALTH DEPARTMENT—CITY OF BALTIMORE

0.46598

152

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hosp. ST.: 4 WARD)

2-FULL NAME Baby Snow

(a) RESIDENCE. No. 331 S. Greenmount Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	—

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 15 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Sathia Snow

11 BIRTHPLACE OF FATHER (city or town) Uniontown (State or country) Pa

12 MAIDEN NAME OF MOTHER Hattie White

13 BIRTHPLACE OF MOTHER (city or town) Fredericksburg (State or country) Va

14 Informant (Address) 1701 O UNIVERSITY

15 Filed ....., 19 ..... Registrar

SEP 17 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-14 1920

17 I HEREBY CERTIFY, That I attended deceased from 9-13, 1920, to 9-14, 1920, that I last saw h. alive on 9-14, 1920, and that death occurred, on the date stated above, at 8 25 P. m.

The CAUSE OF DEATH* was as follows:

Compression of skull during forcep. delivery thru a contracted pelvis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(durstion) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9-14-20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Zeb. V. Hooper, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	SEP 17 1920
20 UNDERTAKER Commissioner Health.	ADDRESS

TION is very important. See Instructions

Spec.—6-9-19—H. P. Co.—1000 Bks.

143-275

D.46599

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46599

CERTIFICATE OF DEATH.

109

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. St.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Katherine Smith

(a) RESIDENCE. No. 1237 Bayard St. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27th 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Seymour

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Katherine Hunard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Record
(Address) J. H. H.

15 Filed SEP 17 1920 19 ROBERT P. HARRISON Registrar
Burial Permit Clerk.

TION is very important. See instruction

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1920, to Sept 16, 1920, that I last saw her alive on Sept 16, 1920 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Umbilical Hernia. Strangulated.

0 (duration) 0 yrs. 0 mos. 1/2 ds.

CONTRIBUTORY (Secondary) Toxaemia. Surgical Shock

0 (duration) 0 yrs. 0 mos. 1/2 ds.

18 Where was disease contracted if not at place of death? at home -

Did an operation precede death? yes Date of 9/16/20

Was there an autopsy? yes

What test confirmed diagnosis? yes.

(Signed) L R Wharton, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Sept 20 1920
20 UNDERTAKER Jos Jacobs & Son	ADDRESS 27 S. Paca St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46600 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46600

CERTIFICATE OF DEATH. 150

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Moore

(a) RESIDENCE. No. 843 N. Carey St. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 20 '20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Richard Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospt Record (Address) Nursey Hospt

15 Filed SEP 17 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/16 1920

17 I HEREBY CERTIFY, That I attended deceased from 8/25, 1920, to 9/16, 1920, that I last saw him alive on 9/16, 1920, and that death occurred, on the date stated above, at 8.35 P. m.

The CAUSE OF DEATH* was as follows:

Intussusception

(duration) yrs. 1 mos. 26 ds.

CONTRIBUTORY (Secondary) Hypertrophic Pyloric Stenosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/16

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lewis D. Ridgely, M. D.

9/16 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westerton Md	9/18 19

20 UNDERTAKER George A. Farley ADDRESS Balto & Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46601

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46601

80

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No 1012 S Ellwood ave ST.: 1st WARD)

2-FULL NAME John Sommer

(a) RESIDENCE. No. 1012 S. Ellwood av ST. 1st WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Sommer

6 DATE OF BIRTH (month, day, and year) June 15—1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Ret

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Henry Sommer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Foldman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louisa Brendel (Address) 1012 S Ellwood ave.

15 Filed SEP 17 1920, 19.. Robert P. Harrison, Registrar

Burial Permit Clerk

CAUTION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-15 1920

17 I HEREBY CERTIFY, That I attended deceased from July 15 1920 to Sept 15 1920

that I last saw h... alive on Sept 15 1920

and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ... M. D.

9/17 1920 (Address) 839 S Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem	9/18 1920

20 UNDERTAKER J. G. Inman

ADDRESS 3000 E Baltimore

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.46602

D.46602

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Weisgerber

(a) RESIDENCE. No. 20 E. Madison ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machine Operator

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Weisgerber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed SEP 17 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1920, to Sept. 17, 1920, that I last saw him alive on September 17, 1920, and that death occurred, on the date stated above, at 9:00 A. m.

The CAUSE OF DEATH* was as follows:

Lung abscess.

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia

* Cachexia (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 9-9-20

Was there an autopsy? not as yet

What test confirmed diagnosis? operation

(Signed) F. A. Holden, M. D.

9/17/20 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 18 1920
20 UNDERTAKER	ADDRESS
William Cook	502 E North

pec.—6-9-19—H. P. Co.—1000 Bks.

D.46603 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46603

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4012 Belle ave ST.: 15 WARD)

REGISTERED NO. 1720

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter N. Cottingham

(a) RESIDENCE. No. 4012 Belle Ave ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 62 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sadie R. Cottingham

6 DATE OF BIRTH (month, day, and year) Aug. 11-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62.	1	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman Ldo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Chas. Zies Sons.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Cottingham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary J. Crouch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Sadie R. Cottingham
(Address) 4012 Belle ave

15 Filed ... 19 Robert F. Harrison Registrar

SEP 17 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1920 to Sept. 16, 1920 that I last saw him alive on Sept. 16, 1920 and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Vernon N. Condon M. D.

, 19 (Address) 750 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	Sept 18 1920
20 UNDERTAKER	ADDRESS
Wm Cook	502 E. North Ave

for Condon North ave & Bolton

TION is very important. Be

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46604 HEALTH DEPARTMENT—CITY OF BALTIMORE D46604

151

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 371 St Helena Ave ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Trapley.

(a) RESIDENCE. NO. 371 St Helena Ave WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 17-1920

7 AGE	Years	Months	Days	If LESS than 1 day 6 hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

000

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Louis Trapley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Isabella Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga.

14 Informant Louis Trapley

(Address) 371 St Helena Ave

15 Filed SEP 18 1920, 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1920 to Sept 17, 1920 that I last saw him alive on Sept 17, 1920 and that death occurred, on the date stated above, at 10 39 m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A.W. Reuer, M. D.

Sept 17, 1920 (Address) St Helena Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Sept 18 1920
20 UNDERTAKER J Herring & Co	ADDRESS 2108 Pleasant

CAUSE OF DEATH. See instructions on back. TION is very important.

U.S.A.

Spec.—8-24-14—M. & T.—2000 Bks.

0.46605

HEALTH DEPARTMENT—CITY OF BALTIMORE

0.46605

CERTIFICATE OF DEATH.

98

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2521 Ashland Ave St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cesare Di Cesare

(Residence in Baltimore: No. 2521 Ashland Ave St.; 15 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Don't Know ..... (Month) ..... (Day), 1878 (Year)

7-AGE,	If LESS than 1 day,
42 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Nicholas Di Cesare

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Virginia Di Cesare

(Address) 2521 Ashland

15-

SEP 18 1920 Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 14 1920, to Sept. 16, 1920, that I saw him alive on Sept. 15, 1920, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

2

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Eugene L. Peruzzo M. D.

Sept. 17, 1920 (Address) 2314 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Redeemer Cem	Sept. 18 1920
20-UNDERTAKER	**ADDRESS**
J. Herwig & Co	2008 Eden

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.46606 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.46606

CERTIFICATE OF DEATH. 105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin near Orchard St. (Rear Living) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Henrietta H Stuckrath

(a) RESIDENCE. No. Franklin near Orchard (Rear Living) St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Stuckrath

6 DATE OF BIRTH (month, day, and year) June 19-1830

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	90	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER John Beltz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Dora Knost

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant Mrs. Geo Stuckrath Jr

(Address) Franklin near Orchard St

15 Filed SEP 18 1920, 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1920, to Sept 16, 1920, that I last saw h er alive on Sept 15, 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Infirmities of age

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Catarrhal Enteritis

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

9/17, 1920 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 20 1920

20 UNDERTAKER John Herweg & Co ADDRESS 2008 Aliceanna

FOR is very important. Be sure every item is correctly answered.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46607 D.46607

CERTIFICATE OF DEATH.

405

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1134 Argyle ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Perkins

(Residence in Baltimore: No. 1134 Argyle St. Life yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown, (Month) (Day) (Year)

7-AGE, 60 yrs. mos. da.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook 071
(b) General nature of industry, business, or establishment in which employed (or employer) Private

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Larry Perkins

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Hill

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Young

(Address) 491 Fulton St

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept. 16th, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15th 1920 to Sept 16th 1920, that I saw h— alive on Sept 15th 1920, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the bowel — Critical

Duration yrs. 2 mos. da.

CONTRIBUTORY (Secondary)

Duration yrs. 1 mos. da.

(Signed) A. Fe Ellis M. D.

9/16, 1920 (Address) 52 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Com — DATE OF BURIAL, Sept. 18 1920

20-UNDERTAKER Samuel Hendley — ADDRESS 518 N Bond

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46608 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46608

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 1 WARD)

REGISTERED NO. 28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willian Dorkins

(a) RESIDENCE. No. 518 Edding st. Laurens ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown 5 Yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Wm. Dorkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M.T.H.

15 Filed SEPT 8 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

THIS IS VERY important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1920, to Sept. 15, 1920, that I last saw him alive on Sept. 14, 1920, and that death occurred, on the date stated above, at 5.10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. J. Tigay, M. D.

9-15-20. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Sept 18 20
20 UNDERTAKER Samuel L. Stendy	ADDRESS 1518 W. Balto

Spec.—5-19-13—M. & T.—500 Blks.

D.46609

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46609

CERTIFICATE OF DEATH.

120V

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 Kelly Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E Hall

Residence in Baltimore: No. 32 Kelly Ave

St.; 60 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1860 (Year)

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Home
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Ind.

PARENTS.

10-NAME OF FATHER, Sam'l Pierce

11-BIRTHPLACE OF FATHER (State or Country), Ind

12-MAIDEN NAME OF MOTHER Hannah Kavelin

13-BIRTHPLACE OF MOTHER (State or Country), Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Bath Carroll

(Address) ..... 32 Kelly ave

15-
SEP 18 1920 Filed ..... 191.....
Robert P. Harrison,
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 15 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1920, to Sept 15 1920, that I saw her alive on Sept 14 1920, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

a Chronic Interstitial Nephritis

Mitral Regurgitation

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C H Beeton M. D.

10. 16, 1920 (Address) Mt Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Sept. 18 1920

20-UNDERTAKER John H. Toadvine

ADDRESS 142 W. Hill St

D.46610 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46610

CERTIFICATE OF DEATH.

159

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1510 Malster ST.: 14 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard L. Bowman

(Residence in Baltimore: No. 1510 Malster St. St.: 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Married

6-DATE OF BIRTH, Dec. 29, 1869
(Month) (Day) (Year)

7-AGE, 51 yrs. 9 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Saloon Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): D43

9-BIRTHPLACE, (State or Country) Virginia

PARENTS.

10-NAME OF FATHER, William Bowman

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary A Bolland

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. R. L. Bowman

(Address) 1510 Malster St.

15- Robert P. Harrison,
Filed SEP 18 1920, 191.....
Burial Permit Cl... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by shooting himself with pistol (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. Hennessy M. D.
(Coroner.)

Sept. 17 1920 (Address) 2802 Eastmoor Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Sept 18, 1920
20-UNDERTAKER	ADDRESS
Geo Leimbach & Co	Govanest

CAUSE OF DEATH must be filled in by physician if possible. Otherwise by undertaker. Every question must be answered if possible. Omissions will cause delay. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D.46611 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46611

CERTIFICATE OF DEATH. 1702

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 Scott ST.; 21 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Seibel

(Residence in Baltimore: No. 510 Scott St. St. 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, January (Month) 6 (Day), 1852 (Year)

7-AGE, 68 yrs. 8 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), New York.

PARENTS.

10-NAME OF FATHER, John McGuire

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. Matthews

(Address) 510 Scott

15-

Filed SEP 18 1920, 191.... Registrar.

Robert P. Harrison,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 19 1920, to Sept 16 1920, that I saw h-er alive on Sept 16 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Septic Chronic.

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 6 ds.

(Signed) Jno Cunningham M. D.

Sept 17, 1920 (Address) 517 Scott

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem'y	Sept. 20, 1920
20-UNDERTAKER Geo Lumbard & Son	ADDRESS 6220 Reisterstown Rd

Important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.46612 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46612

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 Scott St. ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Hall

(a) RESIDENCE. No. 313 Scott St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None.

6 DATE OF BIRTH (month, day, and year) May 22. 20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3.	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) - 000

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Hall.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vermont

12 MAIDEN NAME OF MOTHER Elsie Hagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto-

14 Informant H. Hall (Address) 313 Scott St

15 Filed SEP 18 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 6. 1920. to Sept. 16. 1920. that I last saw him alive on Sept. 16. 1920. and that death occurred, on the date stated above, at 12-Noon.

The CAUSE OF DEATH* was as follows:

Cholera infantum

Ileo. Colitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical

(Signed) M. C. Fuhlinger M. D.

9-18 1920 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Sept 18 1920
20 UNDERTAKER	ADDRESS
Lee Limebach & Son	647 W Balto St

THIS is very Important. See instructions.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46613

HEALTH DEPARTMENT—CITY OF BALTIMORE

41 D46613

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 Hawthorne Road ST.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda R. Whitmore

(a) RESIDENCE. No. 223 Hawthorne Road ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wallace P. Whitmore

6 DATE OF BIRTH (month, day, and year) Nov 14, 1872

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William H. King

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Olivia Mullikin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balti Md

14 Informant Wallace P. Whitmore
(Address) 223 Hawthorne Road

15 Filed ..... 19.. Robert P. HARRISON, Registrar
SEP 18 1920
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1920

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to Sept 17, 1920, that I last saw her alive on Sept 17, 1920, and that death occurred, on the date stated above, at 245 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma
(uterus fundus)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of June 3" 20

Was there an autopsy? Yes

What test confirmed diagnosis? Symptoms were sufficient

(Signed) H. B. Hanna, M. D.

, 19 (Address) 1007 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Sep 20 1920
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be understood by persons unfamiliar with medical terminology. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.46614 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46614

CERTIFICATE OF DEATH. 113

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2029 Woodberry Ave ST.; 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin L. Riderman

(a) RESIDENCE. No. 2029 Woodberry Ave ST., 13 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Riderman

6 DATE OF BIRTH (month, day, and year) Feb. 23-1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor 016

(b) General nature of industry, business, or establishment in which employed (or employer) Timber

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Riderman

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Elanor Hesse

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co (State or country) Md

14 Informant. Mrs. Susan Riderman (Address) 2024 Woodberry Ave

15 Filed SEP 18 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 14. 1920. to Sept 16th. 1920. that I last saw h[illegible] alive on Sept 16th. 1920. and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cirrosis of Liver

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. H. Smith, M. D.

. 19 (Address) Sparks Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olive Cem. Randallstown	Sept 19 1920
20 UNDERTAKER Horace Burgee & Son	ADDRESS 263 Balto St.

TION IS VERY IMPORTANT.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46615

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46615

78V

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3816 Falls Road ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Belle Hinton

(a) RESIDENCE. No. 3816 Falls Road ST., 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 7 mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. H. Hinton

6 DATE OF BIRTH (month, day, and year): Feb. 15-1877

7 AGE — Years: 43 — Months: 7 — Days: 2 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Edna M. Heubeck

(Address): 3816 Falls Road.

15 Filed . 19

Registrar

SEP 18 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1920, to Sept 17, 1920, that I last saw h[illegible] alive on Sept 17, 1920, and that death occurred, on the date stated above, at 5:40 a m.

The CAUSE OF DEATH* was as follows:

E Lankford

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 112 N. 25 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Sept. 20 1920

20 UNDERTAKER: Horace Burgee Son — ADDRESS: 3[illegible] Madison

THIS is very important. See instructions.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 46616

D. 46616

CERTIFICATE OF DEATH.

152

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Taylor's Lane ST.; 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Belle Avery

(Residence in Baltimore: No. 6 Taylors Lane St.; ..... yrs., ... mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Infant

6-DATE OF BIRTH, Sept 17, 1912
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
..... yrs. ..... mos. 1 ds.	.... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm Alexander Avery

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Laura Agnes Hall

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Agnes Hall

(Address) 6 Taylors Lane

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit ....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 18, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 17 1912, to Sept 18 1912, that I saw h[illegible] alive on Sept 18 1912, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows: Incomplete physical development & atelectasis

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward Ghent M. D.

Sept 18, 1912 (Address) 1502 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Morning Star Cem	Sept 19 1912
20-UNDERTAKER	ADDRESS
Edw W. Pye	Edmondson Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46617

8 46617

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 6 Taylor's Lane St. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachel Josephine Avery

(Residence in Baltimore: No. 6 Taylors Lane St.; 1 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH, Sept 17, 1919 (Month) (Day) (Year)

7-AGE, yrs. mos. 1 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work NONE.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm Alexander Avery

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Laura Agnes Hall

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Agnes Avery

(Address) 6 Taylor's Lane

15- Robert P. Harrison,

Filed SEP 18 1920, 191 Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 18, 1919. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17 1919, to Sept 18 1919, that I saw h e alive on Sept 18 1919, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Incomplete physical Development

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward Stuart M. D.

Sept 18, 1919. (Address) 1813 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Morning Star Cemetery

DATE OF BURIAL. Sept 19 1919

20-UNDERTAKER Edw. W. Pye

ADDRESS 963 Edmondson Ave

Spec. 6-9-19—H. P. Co.—1000 Bks.

20.46618 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.46618

CERTIFICATE OF DEATH. 1202

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1423 Light ST.: 24 WARD)

2-FULL NAME Mrs. Margrit Mannion

(a) RESIDENCE. NO. 1423 Light ST., 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 61 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hudson

6 DATE OF BIRTH (month, day, and year) Nov-7-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Flynn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Mary Flood
(Address) 1423 Light St.

15 Filed SEP 18 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH 9-16/20

16 DATE OF DEATH (month, day, and year) Sept 16 1920

17 I HEREBY CERTIFY, That I attended deceased from July 20 1920, to Sept 16 1920, that I last saw h... alive on Sept 16 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Richardson, M. D.

, 19 (Address) 1712 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Sept 20 1920
20 UNDERTAKER	ADDRESS
John J Tobey & Sons	1318 Light

TION is very important. See instructions

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46619

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46619

CERTIFICATE OF DEATH.

REGISTERED NO. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 St. Vincent Apts WARD)

2-FULL NAME Lewis Joseph O'Brennan

(a) RESIDENCE. NO. 27 St Vincent Apts ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 29 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
		5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Lewis O'Brennan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ohio

12 MAIDEN NAME OF MOTHER Maud Bennett

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Mother
(Address) St Vincent Apts

15 Filed SEP 18 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 20 1920 to Sept 15 1920.

that I last saw h alive on Sept 15 1920.

and that death occurred, on the date stated above, at 9 PM m.

The CAUSE OF DEATH* was as follows:

Illeo Colitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pharynx

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) C. S. O. Gaylin M. D.

(Address) 1004 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Sept 18 1920

20 UNDERTAKER McFaherty Sons ADDRESS 1827 N North Ave

TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

20.46620 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.46620

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Beck (Marion E. Tress)

(a) RESIDENCE. NO. 1525 N. Chapel St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress 069

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ed Tress

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) U.T.H.

15 Filed SEP 18 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1920, to Sept. 18, 1920, that I last saw h er alive on Sept. 18, 1920, and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum

(Signed) F. J. Cheyney, M. D.

9-18-20 Address Municipal Tuberculosis Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Sept 20 1920
20 UNDERTAKER	ADDRESS
William Cook	502 S. Hart Av

TION is very important. See instruction on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46621 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46621

CERTIFICATE OF DEATH. 78

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1302 Jefferson ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Zelda Locks

(a) RESIDENCE. No. 1302 Jefferson ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. city

PARENTS

10 NAME OF FATHER Josyh Locks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Edna Frances

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Edna Locks
(Address) 1302 Jefferson St

15 Filed ....., 19.... Robert P. Harrison, Registrar
Burial Permit Clerk.

TION is very important. Be numerous

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to Sept 15, 1920, that I last saw h alive on Sept 14, 1920, and that death occurred, on the date stated above, at 6:15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 1/2 mos. ds.

CONTRIBUTORY (Secondary) Intestines (duration) yrs. 3 wks mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? 0 Date of

Was there an autopsy? 0

What test confirmed diagnosis? 0

(Signed) J. Edward Fisher, M. D.

9-16 1920 (Address) 1612 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemtery	Sept. 19 1920
20 UNDERTAKER	ADDRESS
R. L. Parham	649 W. Lee St.

D.46622 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46622

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1248 E Mad. ST.: 1 WARD) 103

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Comer

Residence in Baltimore: No. 600 N Spring St

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, married WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH: May 22, 1866 (Month) (Day) (Year)

7-AGE: 32 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Labor (b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto, Md

PARENTS.

10-NAME OF FATHER: John Comer

11-BIRTHPLACE OF FATHER (State or Country): Howard Co,

12-MAIDEN NAME OF MOTHER: Susan Shewood

13-BIRTHPLACE OF MOTHER (State or Country): Eastern Shore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Cofer

(Address) 607 Spring St,

15- Robert P. [illegible]

Filed SEP 18 1920, 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9/16, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Acute Gastritis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach

(Duration) yrs. mos. 1/2 ds.

(Signed) H. G. Blades M. D. (Coroner,)

9/17, 1920. (Address) 1429 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem.	Sept 20, 1920
20-UNDERTAKER Wm J. G. Licks	ADDRESS 1302 Harford Av

important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co.—1000 Bks.

046623

HEALTH DEPARTMENT—CITY OF BALTIMORE

137

046623

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 W Hamburg ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl Harris

(a) RESIDENCE. No. 415 W Hamburg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) March 10-1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Glenburnie
(State or country) Maryland

PARENTS

10 NAME OF FATHER Isaac Harris

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Georgianna Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Iva Moore
(Address) 1425 N. 42d Ave Baltimore

15 Filed SEP 19 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

TION is very important. See instruction

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1920, to Sept 17, 1920, that I last saw her alive on Sept 17, 1920, and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Reese, M. D.

9-17 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Furnace Branch Cem	Sept 19 1920
20 UNDERTAKER	ADDRESS
Mrs Bolta Elliott	Garland

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

046624 046624

CERTIFICATE OF DEATH.

REGISTERED NO. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 242 Forrest ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marcolin Graves.

(Residence in Baltimore: No. 242 Forrest St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ? (Month) ? (Day) 186o (Year)

7-AGE, 6o yrs. ? mos. ? ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework 070
(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Marcus Stokes

11-BIRTHPLACE OF FATHER (State or Country), Balto, Md.

12-MAIDEN NAME OF MOTHER, adeline Greene

13-BIRTHPLACE OF MOTHER (State or Country), Balto, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Graves

(Address) 247 Forrest St.

15- SEP 19 1920 Filed....., 191.... ROBERT B KRAUTER Burial Permit Register

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 16, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 13/7/1920, to 16/9/1920, that I saw h[illegible] alive on 16-9-1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows: Cerebro Hæmorrhage

about 3

(Duration) ? yrs. 3 mos. ? ds.

CONTRIBUTORY (Secondary) Uremia General weakness

(Duration) — yrs. 1 mos. ..... ds.

(Signed) Edwin Fiske Bayne M. D.

18/9/, 1920 (Address) 427 N. Carolina

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel cmty — DATE OF BURIAL, Sept 17 1920

20-UNDERTAKER Mrs Robt A Elliott — ADDRESS 1725 Eastland Ave

Important. Sold by [illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

046625

HEALTH DEPARTMENT—CITY OF BALTIMORE

046625

CERTIFICATE OF DEATH.

18

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 914 E Fayette ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Cohen

(Residence in Baltimore: No. 914 E Fayette St.; 16 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ——— (Month) (Day), 1890 (Year)

7-AGE, 30 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Louis Kolker

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Cohen

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible]

(Address) 1411 E. Baltimore St.

15- SEP 19 1920 Filed, 191 ROBERT B KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 17, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 2d 1920, to Sept 17 1920, that I saw h Er alive on 17 1920, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Erysipelas & Gangrene of Skin (Whole body)

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(Duration) yrs. mos. 5 ds.

(Signed) [illegible] M. D.

Sept 18 1920 (Address) 1520 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 914 E Fayette

19-PLACE OF BURIAL OR REMOVAL, Mt Lebanon DATE OF BURIAL, Sept 19 1920

20-UNDERTAKER Jack Lewis ADDRESS 1411 E. Balto

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

046626 105 046626

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Home of Incurables REGISTERED NO.....

CITY OF BALTIMORE: (No. 2100 E. Balto. ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Isaacson

(a) RESIDENCE. No. 2100 E. Balto. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1827

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	93	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of indostry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Home Record (Address) Cremation Records

15 Filed SEP 19 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17th 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1915, to Sept. 10, 1920, that I last saw h.. alive on Sept 10, 1920, and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Ulcerative Colitis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) D. A. Michelson M. D.

, 19 (Address) 1420 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Hebrew Rest	Sept. 19 1920

20 UNDERTAKER Jack Lewis ADDRESS 1411 E. Balto. St

TION IS very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46627

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46627

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4104 Eastern ave ST. 26 WARD)

2-FULL NAME Giovannina Vecchione

(a) RESIDENCE. NO. 4114 Eastern ave ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 8 mos. 24 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 24-1919

7 AGE — Years 8 Months 24 Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Ferdinando Vecchione

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER C. Lazzara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Ferdinando Lazzara
(Address) 4114 Eastern Ave.

15 Filed SEP 19 1920 ROBERT E. LEAUTER Registrar
Burial permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1920, to Sept. 18, 1920, that I last saw her alive on Sept. 18, 1920, and that death occurred, on the date stated above, at 3 15 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) —
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby, M. D.

9/19. 1920 (Address) 1223 N. Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincent Cemetery.	9/19 19
20 UNDERTAKER Georgia J. Butler	ADDRESS 1735 Eastern Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D46628 — 104 — D46628

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Five Mile House ST. York Rd 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Keller Numbers

(a) RESIDENCE. NO. Five Mile House ST., York Rd. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child of Helen + Jesse Numbers

6 DATE OF BIRTH (month, day, and year) Feb 10 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Jesse Numbers

11 BIRTHPLACE OF FATHER (city or town) Newsom
(State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Faulkner

13 BIRTHPLACE OF MOTHER (city or town) Owingstown
(State or country) Md

14 Informant Helen Numbers
(Address) 5 Mile House Govans

15 Filed SEP 19 1920 19 ROBERT B KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1920, to Sept 18, 1920, that I last saw h.... alive on Sept 17, 1920, and that death occurred, on the date stated above, at 3.15 a m.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

(duration) ....yrs. ....mos. 13 ds.

CONTRIBUTORY
(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. K. Hocking, M. D.

, 19 (Address) 5530 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Presbyterian Govans	Sept 20 1920
20 UNDERTAKER	ADDRESS
Williams Cook	502 E North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

946629

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 946629

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3911 Roland Ave ST.: 13 WARD)

2-FULL NAME William C. Robinson

(a) RESIDENCE. NO. 3911 Roland Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Maude Robinson

6 DATE OF BIRTH (month, day, and year) July 3, 1886

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
34	2	15	

8 OCCUPATION OF DECEASED 066

(a) Trade, profession or particular kind of work Salesman

(b) General nature of Industry, business, or establishment in which employed (or employer) Grocery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wm. W. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary S. Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Maude Robinson

(Address) 3911 Roland Ave.

15 Filed SEP 19 1920 16 ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1920

17

I HEREBY CERTIFY, That I attended deceased from Feb, 1919, to Sept 18, 1920, that I last saw him alive on Sept 18, 1920, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? no.

What test confirmed diagnosis? was at State Sanator,

(Signed) [illegible] M. D.

9/18. 1920 (Address) 2020 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Roselyn Cemetery Rockville Md	Sept 19 1920
20 UNDERTAKER Geo J Smith	ADDRESS Forest Park

TION is very important

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46630 HEALTH DEPARTMENT—CITY OF BALTIMORE D46630

CERTIFICATE OF DEATH. 154

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 Carroll ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Bruns

(a) RESIDENCE. NO. 1202 Carroll ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Jan 27/1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 700

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Geo Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs D. Isabell (Address) 202 Carroll St

15 Filed SEP 19 1920 ROBERT F KRAUTER Registrar

Burial Permit Clerk

THIS IS very important. Be sure

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Sept 16 1920, that I last saw h alive on Sept 17 1920, and that death occurred, on the date stated above, at 10-30 A m.

The CAUSE OF DEATH* was as follows:

Infirmities of Old Age

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) W. K. Campbell M. D.

Sept 17 1920 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 20 1920
20 UNDERTAKER L. W. Dill	ADDRESS 3109 Fredk Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

1046631 18

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1046631 120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp. (St.) 16 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Cyrus Robinson

(a) RESIDENCE. NO. 604 N. Carrollton Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14 - 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister 018

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER L. F. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address) J. H. H.

15 Filed SEP 19 1920 19 ROBERT F. KRAUTER Registrar

Burial Permit Given

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1920, to Sept 18, 1920, that I last saw h... alive on Sept 18, 1920, and that death occurred, on the date stated above, at 11 25 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Bronchial

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Prostate Hypertrophy - Chr. Nephritis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) C. L. Deming, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill Cem. DATE OF BURIAL 9/21/20 19

20 UNDERTAKER W. J. Tichnor & Sons ADDRESS Penna. Bath Ave.

Spec. 6-9-19—H. P. Co.—1000 Blks.

0946632

HEALTH DEPARTMENT—CITY OF BALTIMORE

0946632

104

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 S. East Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Yoor

(a) RESIDENCE. No. 810 S. East Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md
(State or country) U.S.A.

PARENTS

10 NAME OF FATHER J. Yoor

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER A Koran

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant J. Yoor
(Address) 810 S. East Ave

15 Filed SEP 19 1920 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to Sept 17, 1920, that I last saw he alive on Sept 17, 1920, and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) mos. 20 ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William G Rylander M. D.

9/18/20 (Address) 801 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	Sept 19 20
20 UNDERTAKER	ADDRESS
Stephen J Gialkowski	1002 S Kenwood Ave

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046633 1046633 120

CERTIFICATE OF DEATH.

REGISTERED NO...

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 710 Portland ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Clark

(a) RESIDENCE. No. 710 Portland ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Charles Clark

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about 56				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER May Beck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles Clark
(Address) 710 Portland

15 Filed SEP 19 1920 ROBERT B KRAUTER Registrar
Burial Permit Olaf

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1920, to Sept 18, 1920, that I last saw her alive on Sept 17, 1920, and that death occurred, on the date stated above, at 1030 a m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Grandle, M. D.

9/18, 1920 (Address) 517 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Sept 20 1920

20 UNDERTAKER Wm Cook — ADDRESS 502 N Wath

TION is very important.

1046634 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046634

CERTIFICATE OF DEATH.

175-0

1-PLACE OF DEATH
CITY OF BALTIMORE (No. St Joseph Hospital St. 12 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert A. Bokel

(Residence in Baltimore: No. Derby Hall St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb (Month) 8 (Day), 1881 (Year)

7-AGE, 39 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer) Iron Ware.

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER, Albert H Bokel

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Emma Connell

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary A. Bokel

(Address) Derby Hall

15-

SEP 19 1920

Filed ..., 191.... ROBERT E KRAUTER Registrar.

Burial Permit Issued

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Fred Edwin Blake M. D.
(Coroner.)

9/15/20 191... (Address) 1439 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Sept 19, 1920

20-UNDERTAKER E A Weidefeld Jr.

ADDRESS 227 Gunnard Ave

S[illegible] 6-9-19—H. P. Co.—1000 Bks.

2046635 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 2046635

CERTIFICATE OF DEATH.

REGISTERED NO. 15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2407 Maryland Ave. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Simms Bowling

(a) RESIDENCE. NO. 2407 Maryland Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	------	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. F. Bowling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Theresa Simms

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm. J. Thompson
(Address) 2407 Maryland Ave.

15 Filed SEP 19 1920, 19 ROBERT I. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1920

17 I HEREBY CERTIFY, That I attended deceased from 6/19/20, 19 , to 9/18/20, 19 20.
that I last saw h[illegible] alive on 9/18/20, 19 , and that death occurred, on the date stated above, at 6.15 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma left tibula
(Local)
(duration) yrs. 6-8 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia - Myocarditis
(duration) 4-5 yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) W. D. Rice, M. D.

, 19 (Address) 1800 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bryantown Charles Co., Md.	9/21/20

20 UNDERTAKER Chas. F. Evans & Son 118 W. Mt. Royal ave.
ADDRESS

TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bka.

D46636 HEALTH DEPARTMENT—CITY OF BALTIMORE D46636

66v

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1390 W. North ave. ST.; 13 WARD)

2-FULL NAME Nathan Packett

(a) RESIDENCE. No. 1390 W. North ave ST.; ..... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mason Packett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Flora Kushner

(Address) 1396 W. North ave.

15 Filed SEP 20 1920 ROBERT F. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept- 18 1920

17 I HEREBY CERTIFY, That I attended deceased from March, 1918, to Sept, 1920, that I last saw him alive on Sept- 18, 1920, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows: over

Hemiplegia Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) 2 yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard C. Silver, M. D.

, 19 (Address) 1914 Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bishop cemetery	9/20/20
20 UNDERTAKER J. Ahern's	ADDRESS 1611 Madison Ave

THIS IS VERY IMPORTANT. USE INK

D.46637 HEALTH DEPARTMENT—CITY OF BALTIMORE D 46637

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Cabin Branch, Curtis Bay. St.: 25 104 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lester L. Ridge.

(Residence in Baltimore: No. Cabin Branch, Curtis Bay. St.; -- yrs., -- 8 mos. -- 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH, January 10th, 1920, 1

(Month) (Day) (Year)

7-AGE, -- yrs. 8 mos. 8 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None. 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, William A. Ridge.

11-BIRTHPLACE OF FATHER (State or Country), Indian Territory

12-MAIDEN NAME OF MOTHER Ethel Linderborn.

13-BIRTHPLACE OF MOTHER (State or Country), Camden N.J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ethel Ridge. (mother).

(Address) Cabin Branch, Curtis Bay.

15- SEP 20 1920 ROBERT E KRAUTER

Filed ....., 191.... Registrar.

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 18th, 1920, 191...

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea Enteritis.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

Sept. 19, 1920. (Address) 1017 S. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem	Sept. 20 1920
20-UNDERTAKER	ADDRESS
F. H. Krauser & Son	703 Hanover St

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046638 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046638

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 153 N. Luzerne ave ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Haupt

(a) RESIDENCE. No. 153 N. Luzerne ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Haupt

6 DATE OF BIRTH (month, day, and year) Dec. 1 [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frederick Budek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germ

12 MAIDEN NAME OF MOTHER Elizabeth Budek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germ

14 Informant Mrs Barnett

(Address) 153 N. Luzerne ave

15 Filed SEP 20 1920, 19 ROBERT R. FRAUTER Registrar

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1920

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1920, to Sept 18, 1920, that I last saw h[illegible] alive on Sept 18, 1920, and that death occurred, on the date stated above, at 2 a, m.

The CAUSE OF DEATH* was as follows:

Streptococcus Viridens Endocarditis Mitral insufficiency Cardiac Hypertrophy (duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Bacteriological & C

(Signed) Geo. E. Bettis, M. D.

, 19 (Address) 6 N. Mich

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept 22 1920
20 UNDERTAKER	ADDRESS
Jos. J. Kerr	156 N. Luzerne

Spec.—8-24-14—M. & T.—2000 Bks.

046639

HEALTH DEPARTMENT—CITY OF BALTIMORE

104 046639

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 N. Clinton ST.; 26 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret A. Seth

(Residence in Baltimore: No. 1619 N. Clinton St.; ..... yrs., 9 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, ... July (Month) 24th (Day), 1920 (Year)

7-AGE, ... yrs. 9 mos. 24 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John W. Seth

11-BIRTHPLACE OF FATHER (State or Country), Alexandria, Va.

12-MAIDEN NAME OF MOTHER Minnie Paines

13-BIRTHPLACE OF MOTHER (State or Country), Alexandria Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Seth

(Address) 1619 N. Clinton St

15- SEP 20 1920 ROBERT F KRAUTER

Filed ....., 191.... Deputy Permit Clerk

Registrar.

Important. See instructions on back.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 18 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 18. 1920, to Sept. 18. 1920, that I saw her alive on Sept. 18. 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

..... (Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) D. W. Jones M. D.

Sept. 18, 1920 (Address) 1013 N. Ellwood Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn cemetery	Sept 21, 1920
20-UNDERTAKER	ADDRESS
P C Gross	1405 McElderry St

Spec. 6-9-15—H. P. Co.—1000 Blks.

Dept 6640

HEALTH DEPARTMENT—CITY OF BALTIMORE

1506640

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Trawinski

(a) RESIDENCE. NO. 611 S Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 19 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Martin Trawinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Lewicki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Record (Address) J. H. H.

15 Filed ....., 19.... Robert F. Frazier Registrar

SEP 20 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18. 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1920, to Sept. 18, 1920, that I last saw h. alive on Sept 18, 1920, and that death occurred, on the date stated above, at 3.20 P.m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation (rectum)

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. C. Danner, M. D.

Sept 18, 1920 (Address) J H H Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Sept 20 1920

20 UNDERTAKER William Gallagher ADDRESS 168 Eastern Ave

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046641

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046641

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621. S. Bethel ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helena Swanick

(a) RESIDENCE. NO. 621. S. Bethel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Max. Swanick

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): " " 037

(c) Name of employer: " "

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Antoni

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Max Swanick (Address): 621. S Bethel ave

15 Filed SEP 20 1920 19.... BOBERT E REANTER Registrar
Burial Permit Clerk

TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9.19. 1920

17 I HEREBY CERTIFY, That I attended deceased from 9.14. 1920, to 9.18. 1920, that I last saw h.. alive on 9.18. 1920, and that death occurred, on the date stated above, at 4 9. m.

The CAUSE OF DEATH* was as follows: Chron. Pulm. T. B.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac asthenia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Shakespeare St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examin.

(Signed) Edwin C. Walzoff, M. D.

Sept 19 1920 (Address) 116 Hisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Sept 21 1920

20 UNDERTAKER: Wm Falkowski — ADDRESS: 148 Eastern

Spec.—6-9-19—H. P. Co.—1000 Bks.

Corrections in red ink made by Dr. Fred B. Smith, Med. June 13 '21

046642

HEALTH DEPARTMENT—CITY OF BALTIMORE

134 046642

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Md. Med. Chir. Hosp. REGISTERED NO.....

CITY OF BALTIMORE. (No. 3 Eliza Wedna St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elena Mienna

(a) RESIDENCE. No. 1201 Gough st. St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mariano Mienna

6 DATE OF BIRTH (month, day, and year) May 9 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Domenico Infissi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Colobba Farone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Mariano Mienna 1201 Gough st

15 Filed SEP 20 1920, 19 ROBERT F. KRAETER Registrar Burial Permit Clerk

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1920.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1920, to Sept. 18, 1920, that I last saw her alive on Sept. 18, 1920, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pregnancy.
(Ectopic).

(duration) yrs. 7 1/2 mos. ds.

CONTRIBUTORY (Secondary) Pernicious Vomiting

(duration) yrs. 2 mos. 1 Month ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical manifestations

(Signed) Fred B. Smith, M. D.

, 19 (Address) M. G. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincent's	Sept 21 1920
20 UNDERTAKER	ADDRESS
Wendell Dippel & Son	378 Mmm

...—6-9-19—H. F. Co.—1000 Bks.

1046643 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046643

CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3006 Elliott ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Dunn

(a) RESIDENCE. NO. 3006 Elliott ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			0 96

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Furnaceman

(b) General nature of industry, business, or establishment in which employed (or employer) Iron Industry

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Anthony

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anthony

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary McAvoy

(Address) 3006 Elliott St.

15 Filed SEP 20 1920 ROBERT E KRAUTER Registrar

Burial Permit Clerk

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16th 1920

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1920, to Sept 16, 1920.

that I last saw him alive on Sept 16, 1920.

and that death occurred, on the date stated above, at 7 45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach (Fundus) (duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M J McAvoy, M. D.

9/19 1920 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	9/20 1920
20 UNDERTAKER J. J. Moran	ADDRESS 3000 E. Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

N.46644

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

046644

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513. N. Exeter ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Brown

(Residence in Baltimore: No. 513. N Exeter St.; 64 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, (Month) (Day) (Year) ; 1856

7-AGE, 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Jas W Brown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Jackson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernestine Watson

(Address) 513 N Exeter

15-

Filed ....., 191.....

Registrar.

SEP 20 1920 ROBERT B. KRAUTER STATE REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Friday, Sept 17th (Month) (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27th 1920, to Sept 17½ 1920, that I saw h[er] alive on Sept 15th 1920, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows: Val. Dis. of Heart & Dropsy

(Duration) Yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Hypostasis

(Duration) yrs. Gradual mos. ds.

(Signed) D. A. Kelly M. D.

Sept. 17, 1920 (Address) 607 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Sept 20, 1920

20-UNDERTAKER Samuel T Hemsley ADDRESS 578 N Eddy

Important. Secretary

Spec.—8-24-14—M. & T.—2000 Bks.

L46645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 W 46645

REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1510 Riverside Ave ST.; 24 WARD)

2-FULL NAME Catherine Virginia Brady. (If not, then duration ..... yrs. 1 mos. ..... ds.)

(Residence in Baltimore: No. 1510 Riverside Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 30 (Day), 1920 (Year)

7-AGE, ... yrs. 3 mos. 17 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None .....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frank J. Brady.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary Ellen Zimmerman

13-BIRTHPLACE OF MOTHER (State or Country) Martinsburg W. Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank J. Brady

(Address) 1510 Riverside Ave.

15- Filed SEP 20 1920, 191.... Robert F. Krauter Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 17 (Day), 1920 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 2 1920, to Sept 17 1920, that I saw h[illegible] alive on Sept 17 1920, and that death occurred, on the date stated above, at 11:30 P.m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) 1 yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Mal Nutrition

(Duration) ..... yrs. ..... mos. 18 ds.

(Signed) O. L. Sanders M. D.

(Address) 1340 N. Charles

Sept 14, 1920

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Sept 20, 1920

20-UNDERTAKER Margaret F. Flynn ADDRESS 1411 Eutaw St.

Important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

046646 HEALTH DEPARTMENT—CITY OF BALTIMORE 1946646

1045

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 Riversidedrive ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary G. Brady

(a) RESIDENCE. No. 1510 Riversidedrive ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 30 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Frank J. Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary Ellen Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Martinsburg W. Va.

14 Informant: Frank J. Brady (Address): 1510 Riversidedrive.

15 Filed SEP 20 1920 19 ROBERT F. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 18 1920 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 3 1920, to Sept 18 1920, that I last saw her alive on Sept 18 1920, and that death occurred, on the date stated above, at 10 20 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. 7 mos. 5 ds.

CONTRIBUTORY (Secondary) Mal-Nutrition

(duration) yrs. 2 mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Was there any Disorders

What test confirmed diagnosis?

(Signed) A. Hellstrom M. D.

19 (Address) 1340 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: Sept 20 1920

20 UNDERTAKER: Margaret G. Flynn

ADDRESS: 1417 Light

TION is very important. See instructions

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046647

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14 1046647

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 2W WARD)

2-FULL NAME Catherine C Lambers.

(a) RESIDENCE. NO. 1032 Madeira St. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child - 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Ernest C Lambers

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Marie Seebold

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Record
(Address) J. H. H.

15 Filed SEP 20 1920 ROBERT F. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1920, to Sept. 18, 1920, that I last saw h. Er. alive on Sept. 18, 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery (Bacillary)

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. C Davison, M. D.

9/19, 1920 (Address) J H H Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Sept 20 1920
20 UNDERTAKER	ADDRESS
James Dignam & Son	1000 S. Paca

TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

046648 119 046648

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 Batavia ave ST.; Hampden WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard Thomas Gardner

(Residence in Baltimore: No. 26 Batavia Ave St.; 70 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... Jan (Month) 31 (Day), 1 (Year)

7-AGE, 71 yrs. 7 mos. 16 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired 034
(b) General nature of industry, business, or establishment in which employed (or employer)..... Retired

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER. Thomas Gardner

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mt Rupert

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... H. B. Smith.....

(Address)..... 26 Batavia Ave.....

15-

SEP 20 1920 ROBERT E KRAUTER

Filed....., 191..... (Date.)

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept (Month) 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1920, to Sept 17 1920, that I saw h[illegible] alive on Sept 17 1920, and that death occurred, on the date stated above, at 8 P, m.

The CAUSE OF DEATH* was as follows:

..... Acute Parenchymatous
..... Nephritis
..... (Duration)..... yrs..... mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Parenchymatous Nephritis

Stenosis (Duration)..... yrs..... mos. 2 ds.

(Signed)..... B. Long M. D.

Sept 20, 191... (Address) 27 Hanford Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Western Cemetery

DATE OF BURIAL. Sept 20, 1920

20-UNDERTAKER W M Routson

ADDRESS 2258 N Mt.

Spec.—8-24-14—M. & T.—2000 Bks.

0 46649 HEALTH DEPARTMENT—CITY OF BALTIMORE 1946649

415

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2860 Woodbrook Ave St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H. Flagel

(Residence in Baltimore: No. 2860 Woodbrook ave St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July 6, 1862 (Month) (Day) (Year)

7-AGE, 58 yrs. ..... mos. 12 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired 034
(b) General nature of industry, business, or establishment in which employed (or employer)..... Grocery

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Elijah Flagle

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Julia Warrenfeltz

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Catherine Flagle

(Address) 2860 Woodbrook

15- SEP 20 1920 ROBERT P. KRAUTER

Filed ....., 191... Registrar. Deputy Registrar Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 19, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16 1920, to Sept 19 1920, that I saw him alive on Sept 18 1920, and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Cancer of Sigmoid Flexure

..... (Duration) About yrs. 9 mos. ..... ds.

CONTRIBUTORY, Ulcer of Stomach
(Secondary)

From Cancer (Duration) ..... yrs. 2 mos. ..... ds.

(Signed) O. H. Dreyer M. D.

Sept 20, 191... (Address) 1819 N. Milton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... dy. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemt

DATE OF BURIAL, Sept 21, 1920.

20-UNDERTAKER H M Routson

ADDRESS 230 N Green

Important. See instructions.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046650 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046650

CERTIFICATE OF DEATH. 38

1-PLACE OF DEATH So. Balto. Gen. Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1235 Wall ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mamie Ruth Winters.

(a) RESIDENCE. NO. 1235 Wall ST., 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 11 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Christian Winters

6 DATE OF BIRTH (month, day, and year) Sept 22, 1895

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
24	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory hand 886

(b) General natore of industry, business, or establishment in which employed (or employer) Tobacco

(c) Name of employer Kraus + Co.

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland.

PARENTS

10 NAME OF FATHER Christian Ott

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Bailey

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Irene Amelia (sister) (Address) 1235 Wall St.

15 Filed SEP 20 1920 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1920.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1920, to Sept. 19, 1920, that I last saw her alive on Sept. 19, 1920, and that death occurred, on the date stated above, at 5.45a m.

The CAUSE OF DEATH* was as follows:

Bilateral salpingitis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) shock + hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes. Date of Sept. 18, 20

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. D. Ponte Jr. M. D.

. 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Ver. M. E. burial	Sept 21 19
20 UNDERTAKER	ADDRESS
Mrs J E Evans + Sons	1020 W. Lexington

TION is very important. See instructions on reverse side.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

046651

REGISTERED NO. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: No. St. Agnes Hospital ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lucinda Reeder

(a) RESIDENCE. NO. 260 S. Kilbourn Ave ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem'l

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Chas F. Reeder

6 DATE OF BIRTH (month, day, and year): June 5 1859

7 AGE: Years 61 Months 3 Days 2 If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md Balto

PARENTS

10 NAME OF FATHER: John Bair

11 BIRTHPLACE OF FATHER (city or town) (State or country): New Hampshire

12 MAIDEN NAME OF MOTHER: Sarah Ogle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md Balto

14 Informant (Address): Emma Luckett 1667 Talbot ave

15 Filed SEP 20 1920 19 ROBERT H. [illegible] Registrar
Burial Permit Clerk

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 17, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1920, to Sept. 17, 1920, that I last saw h[illegible] alive on Sept. 17, 1920, and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Diabetes → acidosis.
chronic nephritis.

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory + clinical.

(Signed) Paul E. Brown. M. D.

19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cimetery — DATE OF BURIAL Sept 20 1920

20 UNDERTAKER: H B Kephart — ADDRESS 2236 Fred'k Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-46652

046652

CERTIFICATE OF DEATH.

64 V

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 410 N. Gilmore ST. 19th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Vincient Spears

(a) RESIDENCE. No. 410 N.Gilmor ST., 19th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Negro.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Rebcca.Sp ears

6 DATE OF BIRTH (month, day, and year) Oct. 8th. 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	9	11	

8 OCCUPATION OF DECEASED

074

(a) Trade, profession or particular kind of work Stevadore

(b) General nature of industry, business, or establishment in which employed (or employer) Emplyd to loading ships

(c) Name of employer Merchant and Miners S.S. Co

9 BIRTHPLACE (city or town) (State or country) St.Marys Co. Md.

PARENTS

10 NAME OF FATHER John A. Spears

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Marys Co. Md.

12 MAIDEN NAME OF MOTHER Lucy Smallwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Marys Co. Md.

14 Informant Mary Spears (wife)
(Address) 410 N. Gilmor St.

15 Filed SEP 20 1920 19 ROBERT F. LEATHERBURY Registrar
REGISTRAR OF VITAL STATISTICS

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/19/'20. 19

17

I HEREBY CERTIFY, That I attended deceased from Sept. 18th. 1920, to Sept. 19th 1920.

that I last saw h.im alive on Sept. 19th. 1920 19.

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Appoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson M. D.

. 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse aide for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	Sept 22 1920
20 UNDERTAKER	ADDRESS
Laverne Campbell	1344 McCulloh

Spec.—6-9-19—H. P. Co.—1000 Blks.

46653 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46653

150V

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mrs Hoof. St.: 11 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Johnson

(a) RESIDENCE. No. 10 Hamilton St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9/18/20

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None nod

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Jane Floyd.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Knight Record

(Address) Mary Knight

15 Filed SEP 20 1920 16 Robert P. Garrison, Registrar

Burial Permit Clerk.

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/19 1920

17

I HEREBY CERTIFY, That I attended deceased from 9/18 1920 to 9/19 1920

that I last saw h[illegible] alive on 9/19/20 1920

and that death occurred, on the date stated above, at 8/15 p. m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm D. Ruth M. D.

9/20 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	9/20/20

20 UNDERTAKER Jno A Farley Fulton & Fayette ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46654 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46654

CERTIFICATE OF DEATH. 8-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1203 Ashland Ave ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annette Cohen

(a) RESIDENCE. No 1203 ashland Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2/8/1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Edward A Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Mary K. Roeder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harper's Ferry West Va

14 Informant E. A. Cohen

(Address) 1203 ashland ave

15 Filed SEP 20 1920 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-20 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1920, to Sept 19, 1920, that I last saw her alive on Sept 19, 1920, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. 4 mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Harpers Ferry

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) A. Hornstein, M. D.

9/20, 1920 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	Sept 20 1920
20 UNDERTAKER	ADDRESS
Jack Lewis	1411 E. Balto

TION IS VERY important. USE WRITE

Spec.—6-9-19—H. P. Co.—1000 Bks.

2046655 HEALTH DEPARTMENT—CITY OF BALTIMORE 2046655

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes' Hospital ST.: 14 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Krish

(a) RESIDENCE. NO. St Vincents Asylum ST., WARD Holy Angels

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Jan. 19 09/19

7 AGE Years 1 Months 8 Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Peter Krish

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Katie Kemplar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant (Address) Peter Krish Brentfield Md

15 Filed ....., 19.... Robert P. Harrison, Registrar

SEP 20 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1920, to Sept 20, 1920, that I last saw her alive on Sept 20, 1920, and that death occurred, on the date stated above, at 12.45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Indigestion

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) E. P. Greenawald, M. D.

(Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	9-21 1920
20 UNDERTAKER	ADDRESS
E B Hale	115 E Mt St

Spec.—6-9-19—H. P. Co.—1000 Bk.

D.46656 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46656

CERTIFICATE OF DEATH. 104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1164 Carroll ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer Lee Kurtz

(a) RESIDENCE. NO. 1164 Carroll ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 3 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry A. Kurtz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Ruth M. Tracy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant (Address) Henry A. Kurtz 1164 Carroll St.

15 Filed SEP 20 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19, 1920.

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1920, to Sept 19, 1920, that I last saw h alive on Sept 18, 1920, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Mary Stacy, M. D.

9/19 1920 (Address) 727 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem.

DATE OF BURIAL Sept. 20 1920.

ADDRESS

20 UNDERTAKER Mr + Mrs John W. Senfel 8 N Fayette

TION IS VERY IMPORTANT.

Spec.—8-24-14—M. & T.—2000 Bks.

D.46657

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46657

CERTIFICATE OF DEATH.

151

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2125 Ls Cullob ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME name not given

(Residence in Baltimore: No. 2125 Ls Cullob St.; ....yrs. ....mos. 15 min ~~da~~)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Colored	

6-DATE OF BIRTH, Sept. (Month) 15 (Day), 1920 (Year)

7-AGE, ...yrs. ....mos. 15 min. ....da. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....None....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), 2125 Ls Cullob St.

PARENTS.

10-NAME OF FATHER, John H. Rhodes

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Katie Gross

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katie Rhodes

(Address) 2125 N. Cullob

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 15 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from at birth 191.., to death 191.., that I saw h[illegible] alive on Sept. 15, 12 m. 1920, and that death occurred, on the date stated above, at 1:15 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth (about 5 mos. gestation) Other not known than cause of miscarriage (Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) ..... (Duration) ....yrs. ....mos. ....da.

(Signed) J. F. Chenowith M. D.

Sept. 15, 1920 (Address) 3226 Gladstone Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Sept 20 1920

20-UNDERTAKER George H. Holland ADDRESS 1631 Druid Hill Ave

Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0.46658

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46658

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora Mobley

(a) RESIDENCE. No. 1147 Fremont Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Mobley

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Robert Moses

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records,
(Address) New City Hospital

15 Filed ..... 19.. Registrar

THIS is very important. Be sure that

SEP 20 1920 Robert P. Harrison

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17, 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1920, to Sept. 17, 1920, that I last saw her alive on September 17, 1920, and that death occurred, on the date stated above, at 2:00 A.M. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis

hypertension (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No especial test.

(Signed) W. B. Harman, M. D.

9/17/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wash Hour Fi. C	Sept 20 1920
20 UNDERTAKER	ADDRESS
Geo. T. A. Gibson	513 Fawn St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46659 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46659

CERTIFICATE OF DEATH. 66-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST.: 21 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME James A Ligdon

(a) RESIDENCE. No. 603 N. Wash ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. — mos. — ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mrs. Julia R. ~~Jane~~ A Ligdon

6 DATE OF BIRTH (month, day, and year) 1871 July 2

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker 086

(b) General nature of industry, business, or establishment in which employed (or employer) Not known

(c) Name of employer Not known

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs. James A Ligdon

(Address) 603 N Wash St

Filed SEP 20 1920 Robert P. Harris

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19, 1920

17 I HEREBY CERTIFY, That I attended deceased from 9-13-20, 19, to 9-19-, 19 20.

that I last saw him alive on 9-18, 19 20.

and that death occurred, on the date stated above, at 6:50 p.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Thrombosis)

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) F. a. Holden, M. D.

9-19, 1920 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt O Cinet	Sept 21 1920
20 UNDERTAKER Geo W Little	ADDRESS 531 N Fremont

TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46660 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46660

CERTIFICATE OF DEATH.

REGISTERED NO. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Conquest

(a) RESIDENCE. No. 1422 McCullough St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: John Lewes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Barbara Ellis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Hospital Records, New City Hospital.

15 Filed SEP 20 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 18, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1920 to September 18, 1920, that I last saw her alive on September 17, 1920, and that death occurred, on the date stated above, at 2:00 A. m.

The CAUSE OF DEATH* was as follows:

Acute myocardial insufficiency

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis. (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Microspecial test.

(Signed) E. H. Harris M. D.

9-18-20 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peter's Cemetery	Sept. 21 1920
20 UNDERTAKER: John M. Johnson	ADDRESS 1234 Eutaw St.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.46661 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46661

CERTIFICATE OF DEATH. 30

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 Battery ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Vernice Gardner

(a) RESIDENCE. No. 1121 Battery ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
10	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work school girl

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Allyn A Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D C

12 MAIDEN NAME OF MOTHER Carrie Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Allyn A Gardner
(Address) 1121 Battery ave

15 Filed SEP 20 1920 19 Robert P. Harrison, Registrar

TION is very important. See instructions on back of cer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-20 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 9. 1920, to Sept 20 1920, that I last saw h[er] alive on Sept 19 1920, and that death occurred, on the date stated above, at 7:15 A m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Lumbar puncture

(Signed) G D Buxton, M. D.

9-20 1920 (Address) 301 E Lorse St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON PARK. DATE OF BURIAL: SEP 22 1920

20 UNDERTAKER: JOHN F. DENNY ADDRESS: 715 LIGHT ST.

Spec.—8-24-14—M. & T.—2000 Bks.

D.46662

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46662

CERTIFICATE OF DEATH.

104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 N Stricker ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gordon Lonis Crockett

Residence in Baltimore: No. 16 N. Stricker St. St.; — yrs., 5 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Single

6-DATE OF BIRTH, March (Month) 27 (Day), 1920 (Year)

7-AGE, — yrs. 5 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... —

9-BIRTHPLACE, (State or Country), Balto, Md

PARENTS.

10-NAME OF FATHER, Edgar Lonis Crockett

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Blanche Charnock.

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Blanche C. Crockett

(Address)..... 16 N. Stricker St.

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 18 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 2 – 1920, to Sept 18 1920, that I saw him alive on Sept 18 1920, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

myocarditis

..... (Duration) — yrs. — mos. 13 ds.

CONTRIBUTORY (Secondary) ileo-colitis

..... (Duration) — yrs. — mos. 22 ds.

(Signed) Chester Riland., M. D.

9-18-, 1920. (Address) 2532 Edmondson ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, LOUDON PARK

DATE OF BURIAL, SEP 20 1920, 191...

20-UNDERTAKER JOHN F. DENNY

ADDRESS 715 LIGHT ST.

SEP 20 1920 Robert F. Harrison,
Burial Permit Clerk.

D.46663 HEALTH DEPARTMENT---CITY OF BALTIMORE D.46663

CERTIFICATE OF DEATH

64 REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 4824 Park Heights Av. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Loeffler

(Residence in Baltimore: No. 4824 Park Heights Av St.; 6 yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Feb (Month) 2 (Day), 1850 (Year)

7-AGE: 70 yrs. 7 mos. 16 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: August Loeffler

11-BIRTHPLACE OF FATHER (State or country): France

12-MAIDEN NAME OF MOTHER: Catherine Hairs

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jas. H. Jenkins

(Address) 4827 Park Heights

15- FEB 20 1920 Filed ..... 191 ..... Robert P. Harrison, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sep (Month) 18 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 16, 1920, to, Sep 18 1920; that I saw h alive on Sep 18 1920; and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs 1 mos. 2 ds.

Contributory (SECONDARY)

(Duration) yrs mos. ds.

(Signed) Wm L Bevlan M. D.

Sept 18, 1920 [Address] 4854 Park Heights

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: Sept 21 1920

20-UNDERTAKER: B Schlenmans Son — ADDRESS 1027 Hanover St

PETITION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46664 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46664

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 Edmondson Ave St.: 17 WARD)

2-FULL NAME Caroline Mausle

(a) RESIDENCE. No. 711 Edmondson Ave St., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Mausle

6 DATE OF BIRTH (month, day, and year) May 25-1835

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Bardenheier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louise Mausle (Address) 711 Edmondson Ave

15 Filed SEP 20 1920 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20th 1920

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1920, to Sept 17, 1920, that I last saw h.. alive on Sept 17, 1920, and that death occurred, on the date stated above, at 12 30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas Heidemann M. D.

Sept, 19 20 (Address) 150 N McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Ridge	Sept 20th 1920
20 UNDERTAKER Graham F. Walker	ADDRESS 723 Arlington Ave

THIS is very important. See instructions.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46665 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46665

CERTIFICATE OF DEATH.

92

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1314 W Lexington St.: 19 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Gordon Long

(a) RESIDENCE. No. 1314 W Lexington St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. — mos. 29 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 22, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34		29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Time Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) 009
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm H. Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. Garrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mary A. Balderston
(Address) 1314 W. Lexington St.

15 Filed SEP 20 1920 19... Robert P. Morrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-19 1920

17 I HEREBY CERTIFY, That I attended deceased from 9-13-20, 19..., to 9-19-20, 19..., that I last saw h... alive on 9-19-20, 19..., and that death occurred, on the date stated above, at 6 15 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. H. Wiesner M. D.

9/20, 19... (Address) 1502 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept 22 19...
20 UNDERTAKER George J. Smith	ADDRESS 1800 W Fayette

FILL IN very important. Be sure to write plainly.

Spec.—8-24-14—M. & T.—2000 Bks.

D.46666

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46666

CERTIFICATE OF DEATH.

105

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for aged of the M. E. St. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Sarah A. H. Marr.

(Residence in Baltimore: No. S. W. cor Fulton Ave and Franklin St.; ....yrs. Life mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Febry (Month) 19 (Day), 1830 (Year)

7-AGE, 90 yrs. 7 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None. 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Jos. J. Merriken

11-BIRTHPLACE OF FATHER (State or Country) Anne Arundel Co. Md.

12-MAIDEN NAME OF MOTHER Alphonza Hall.

13-BIRTHPLACE OF MOTHER (State or Country) Chestertown Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Etta Dudley

(Address) 700 Fulton ave

15-

Filed SEP 20 1920, 191.... Robert P. Harrison, Registrar.

Burial Permit C[illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 19 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 3 1920, to Sept 19 1920, that I saw h[illegible] alive on Sept 17 1920, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

.....

Gastro Enteritis

.....

..... (Duration) ~ yrs. 1 mos. ~ ds.

CONTRIBUTORY (Secondary) Inanition and Senility

..... (Duration) ~ yrs. 1 mos. ~ ds.

(Signed) Geo. C. Shannon M. D.

Sept 20, 1920 (Address) 700 Fulton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Md. Asbury | DATE OF BURIAL, ..., 191...

20-UNDERTAKER George Smith | ADDRESS [illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

D.46667

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46667

150

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child's Hospital ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margarette Cornell

(Residence in Baltimore: No. Nursery & Child's Hospital St.; 1 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept. (Month) 26 (Day), 1919 (Year)

7-AGE, 1 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None 000

9-BIRTHPLACE, (State or Country), Baltd. Md

PARENTS.

10-NAME OF FATHER, James Cornell

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Margarette Jekel

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Margarette Cornell

(Address) 2 E. Biddle St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 19 (Day), 1920 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Dec 4 1919, to Nov 19 1920 that I saw h.. alive on Nov 19, 1920. and that death occurred, on the date stated above, at 1230 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease (Mitral) (Congenital)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Lowell S. Knight M. D.

Nov. 20, 1920 (Address) 1200 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. 1 mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, ..., 191...

20-UNDERTAKER Geo. J. Weild

ADDRESS 1525 Eutaw

Important. See instructions.

Robert P. Harrison, Burial Permit Clerk

SEP 21 1920

D.46668 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46668

Marsolek

175-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Johns Hopkins Hospital ST.) WARD)
REGISTERED No. C.....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rudolph Marsolek.
(Residence in Baltimore: No. 809 N Madeira St.: 7 yrs., 9 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Child

6-DATE OF BIRTH, Dec 14, 1912
(Month) (Day) (Year)

7-AGE, 7 yrs. 9 mos. 4 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.
10-NAME OF FATHER, Sylvester Marsolek
11-BIRTHPLACE OF FATHER (State or Country), Poland
12-MAIDEN NAME OF MOTHER Anna Wachary
13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Sylvester Marsolek
(Address) 809 N Madeira St

15-
Filed ....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 17, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH was as follows:
Fracture Skull
Multiple Injuries
(Duration) ..... yrs. ..... mos. 6 hrs.
CONTRIBUTORY (Secondary) Shock
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo Edmund Rhode M. D.
(Coroner.)
9/19/20 191... (Address) 1137 E Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Sept 21, 1920
20-UNDERTAKER	ADDRESS
Frank Crack Son	1116 Eastland Ave

important. See instructions on back of certificate.

SEP 20 1920 Robert P. Harrison, Register

Spec.—8-24-14—M. & T.—2000 Bks.

D.46669 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46669

CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 N Chapel ST.; 7 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosie Pozdeska

(Residence in Baltimore: No. 509 N Chapel St. St.: 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, Not Known (Month) ..... (Day), 1880 (Year)

7-AGE. 40 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Work
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Jan Mucha

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Marie Milly

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie Mucha

(Address) 509 N Chapel st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 19, 1920 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from June 3 1920, to Sept 19 1920, that I saw h[illegible] alive on Sept 19 1920, and that death occurred, on the date stated above, at 945 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) ..... yrs. 14 mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) [illegible] M. D.

Sept 20, 1920 (Address) 250 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residance .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Sept 21, 1920

20-UNDERTAKER Eddy Enack Son — ADDRESS 1906 Hubbard

Robert P. Harrison,
Deputy Register.

Spec.—8-24-14—M. & T.—2000 Bks.

Marooek

D.46670 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46670

CERTIFICATE OF DEATH.

9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 N Rose St.; 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Morooek

(Residence in Baltimore: No. 822 N Rose St.; 2 yrs., 5 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. March 10, 1918. (Month) (Day) (Year)

7-AGE. 2 yrs. 5 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Josef Morovek

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Agnes Masek

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josef Morovek

(Address) 822 N. Rose St.

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 20, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 19 1920, to Sept 20 1920, that I saw h[illegible] alive on Sept 20 1920, and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(Duration) yrs. mos. ds.

(Signed) W. [illegible] M. D.

(Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Hill — DATE OF BURIAL, Sept 21, 1920

20-UNDERTAKER Frank Crockett — ADDRESS 1906 Eden Ave

Robert P. Harrison, 20 1920

D.46671 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46671

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 2619 St Paul Street ST.; 12 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maud Jones Walden
(Residence in Baltimore: No. 2619 St Paul Street
St.; yrs. about 55 years. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. About ? 1865
(Month) (Day) (Year)

7-AGE. About 55 yrs. ? mos. ? ds.
If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 037
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country). Baltimore-Md

PARENTS.
10-NAME OF FATHER. Bennett Jones
11-BIRTHPLACE OF FATHER (State or Country). Elkton-Md
12-MAIDEN NAME OF MOTHER Emma V. Comegys
13-BIRTHPLACE OF MOTHER (State or Country). Churchhill-Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mr. Van B. Kleinfelter Jr.
(Address) 206 Oakdale Road-City.

15-
Filed ....., 191....
Registrar.

SEP 20 1920
Robert P. Harrison,
Burial Permit Clerk.

CAUSE OF DEATH to be plainly written. Every question must be answered if possible. Omissions will cause delay. Be particular and exact. Use ink. Spell out all words. Do not use abbreviations or ditto marks. Be sure to answer questions 16, 17, 18 and 19 as they are very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 19, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Disease of heart
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)
Sept 20 1920 (Address) 2618 Rolston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Middleburg-Carroll Md	....., 19....
20-UNDERTAKER. C. H. MOWEN COMPANY (WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 46672

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46672

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 133 W. 20 ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Summers

(a) RESIDENCE. NO. 133 W. 20, ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 1871

7 AGE: Years 49 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cambridge Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Barbara Summers (Address) 133 W. 20 St

15 Filed SEP 21 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1920, to Sept. 19, 1920, that I last saw h[illegible] alive on Sept. 18, 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows: Mitral regurgitation

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardio-vascular disease

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Dan'l C. Robinson, M. D.

(Address) 530 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: mt auburn — DATE OF BURIAL: Sept 21 1920

20 UNDERTAKER: Joseph A Farry — ADDRESS 2519 Division St

IMPORTANT. See instructions on back.

pec.—6-9-19—H. P. Co.—1000 Bks.

D 46673

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46673

CERTIFICATE OF DEATH.

64 V

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 518 E. Eager ST.; 10 WARD)

2-FULL NAME Mary V Kennedy

(a) RESIDENCE. NO. 518 E - Eager ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Joseph Kennedy

7 DATE OF BIRTH (month, day, and year) Sept 17 1853

8 AGE — Years: 67 — Months: — Days: 2 — If LESS than 1 day, ...hrs. or ....min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer:

10 BIRTHPLACE (city or town) (State or country): Scotland

10 NAME OF FATHER: Peter Short

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Katherine McNally

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Margaret McNulty (Address): 518 E - Eager

15 Filed SEP 21 1920 19.... Registrar: Robert F. Harrison Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1920, to Sept 19, 1920, that I last saw her alive on Sept 19, 1920, and that death occurred, on the date stated above, at 1145 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) .... yrs. .... mos. 2 dys

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? 518 E Eager

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Faulkner M. D.

9/20 1920 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral | DATE OF BURIAL: Sept 21 1920

20 UNDERTAKER: William Cook | ADDRESS: 508 N Gay

Spec. 6-9-19—H. P. Co.—1000 Blks.

D46674 HEALTH DEPARTMENT—CITY OF BALTIMORE D46674

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 259 N Schroeder ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo H. Brooke

(a) RESIDENCE. No. 259 N Schroeder ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie T Brooke

6 DATE OF BIRTH (month, day, and year) Unknown 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md.

PARENTS

10 NAME OF FATHER Nathaniel Barton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sydney Barton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Clifford T Brooke (Address) 1505 W Lanvale St

15 SEP 21 1920 ROBERT B KNAPPE Acting Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 10, 1920, to Sept 18, 1920, that I last saw h alive on Sept 17, 1920, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Organic Dis of Heart
Arterio Sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm. Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J J Woodward, M. D.

, 19 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Sept 20 1920
20 UNDERTAKER	ADDRESS
Samuel S Hemsley	578 M[illegible]

TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46675 HEALTH DEPARTMENT—CITY OF BALTIMORE D46675

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 432 N. Eden St. 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lenard Morris

(a) RESIDENCE. No. 432 N Eden ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 16. 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer H. Jackam

9 BIRTHPLACE (city or town) (State or country) Balto, city

PARENTS

10 NAME OF FATHER Jackson Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Pritty, Curry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Percilla Morris

(Address) 432 N Eden St.

15 Filed SEP 21 1920 ROBERT E KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 11. 1920. to Sept 18. 1920. that I last saw h in alive on Sept 17 1920. and that death occurred, on the date stated above, at 12 am m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Tofemia

(duration) yrs. 3 wks

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J. Edward Fisher M. D

9-20-20 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery DATE OF BURIAL Sept. 22 1920

20 UNDERTAKER Milton. Davis ADDRESS 413 N Eden St

TION is very important. See instructions on

Spec.—8-24-14—M. & T.—2000 Blks.

1046676

HEALTH DEPARTMENT—CITY OF BALTIMORE

93 1046676

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 S. Caroline ST.; 3 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Cherry—

(Residence in Baltimore: No. 107 S. Caroline St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, not known, (Month) (Day) 1851 (Year)

7-AGE, 39 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) 04

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), not known

12-MAIDEN NAME OF MOTHER not known.

13-BIRTHPLACE OF MOTHER (State or Country), not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Estella Cherry

(Address) 107 S. Caroline st

15- SEP 21 1920 ROBERT B KRAUTER
Filed....., 191.... Registrar.

Burial Permit Issued

important. See instructions on back of this sheet.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 19th, (Month) (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 9 1920, to Sept 19th 1920, that I saw h[illegible] alive on Sept 18th 1920, and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Acute Pleurisy
(not tubercular)
(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis
(Duration) not known yrs. mos. 2 ds.

(Signed) Harry F. Brown M. D.

Sept 20 1920 (Address) 1501 Presstman st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel

DATE OF BURIAL, Sept 21, 1920

20-UNDERTAKER Julius W Henderson

ADDRESS 1502 E Monument

Spec.—6-9-19—H. P. Co.—1000 Blks.

D-46677 HEALTH DEPARTMENT—CITY OF BALTIMORE 046677

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3853 Quarry Ave (St.) 13 (Ward)

2-FULL NAME Caroline Kemp

(a) RESIDENCE. No. 3853 Quarry Ave (St.) Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nickalis Kemp

6 DATE OF BIRTH (month, day, and year): Nov 11 1854

7 AGE: Years 65 Months 11 Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 837

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Horn

11 BIRTHPLACE OF FATHER (City or town) (State or country): Prussia

12 MAIDEN NAME OF MOTHER: Honeretta Hafter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Nickalis Kemp 3853 Quarry Ave

15 Filed SEP 21 1920 19 ROBERT E. ... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 17 1920, to Sept 19 1920, that I last saw her alive on Sept 18 1920, and that death occurred, on the date stated above, at 240 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

complicated by

Dilatation of Heart

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema of Abdomen

Acute (duration) 7 yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) R B Norment, M. D.

, 19 (Address) 3047 Chelsea Terr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Sept 21 1920
20 UNDERTAKER	ADDRESS
Chenoweth Son	Lexington

Spec.—6-9-19—H. P. Co.—1000 Bks.

046678 HEALTH DEPARTMENT—CITY OF BALTIMORE 046678

CERTIFICATE OF DEATH. 1082

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (NO. Mercy Hosp ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Curtis Evans

(a) RESIDENCE. NO. 23 N. Linwood Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 23, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	14	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delta, Penna.

PARENTS

10 NAME OF FATHER John Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Kate ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant John Evans (Address) 23 N. Linwood ave

15 Filed SEP 21 1920 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 1920

17 I HEREBY CERTIFY, That I attended deceased from 9/6 1920, to 9/20 1920, that I last saw h[illegible] alive on 9/20 1920, and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis +
Intestinal obstruction

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9/17 & 9/19

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Irving D. Pudgley M. D.

9/20 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Delta, Penn	9/22 1920

20 UNDERTAKER J. J. Moran

ADDRESS 3006 E Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46679

D46679

CERTIFICATE OF DEATH.

REGISTERED NO. 79 D46679

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 Schaffer Ave ST.: Hamilton WARD)

2-FULL NAME Edward C. Mullan

(a) RESIDENCE. NO. 22 Schaffer Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 11 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eupha A. Mullan

6 DATE OF BIRTH (month, day, and year) Sept 19th 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	—	—	

8 OCCUPATION OF DECEASED 029

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) Republic El. Light Co

(c) Name of employer S. W. Greig

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Edward Mullan

11 BIRTHPLACE OF FATHER (city or town) Sacks Md
(State or country)

12 MAIDEN NAME OF MOTHER Rosalie Leantard

13 BIRTHPLACE OF MOTHER (city or town) Sacks Md
(State or country)

14 Informant Eupha A. Mullan
(Address) 2012 Schaffer ave Hamilton

15 Filed SEP 21 1920 ROBERT F. LEATHERS Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to Sept 19, 1920 that I last saw him alive on Sept 19, 1920, and that death occurred, on the date stated above, at 2.05 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geary A. Long, M. D.

, 19 (Address) 27 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Sept 22nd 1920

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument st

TION is very important. See that

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46680

HEALTH DEPARTMENT—CITY OF BALTIMORE

40 D46680

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 Carroll St. 21 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas Knapp

(a) RESIDENCE. No. 1106 Carroll St. 21 Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Eliz Knapp

6 DATE OF BIRTH (month, day, and year): Dec 6 1862

7 AGE: Years 57 Months 9 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer 063

(b) General nature of industry, business, or establishment in which employed (or employer): Newspaper

(c) Name of employer: Sun Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Chas Knapp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Koch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs C J Knapp 1106 Carroll St

15 Filed ..... 19..... Registrar

SEP 21 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 1920 to Sept 18 1920, that I last saw h[illegible] alive on Sept 18 1920, and that death occurred, on the date stated above, at 10 9 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Schwerin M. D.

19 (Address) 1120 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Sept 21 1920

20 UNDERTAKER: Geo Lewis Cook & Son — ADDRESS: 647 N Eutaw

TION is very important. See instructions on

DOROTHY F. [illegible]

Vital Statistics Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46681 ✓ D46681

D46681

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 903 Hollins St ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Rita Cowan

(a) RESIDENCE. NO. 903 Hollins St. ST., WARD.
(Usual place of abode) (if nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan'y 4th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frank J Cowan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Marie E. Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Frank J Cowan (Address) 903 Hollins St.

15 Filed SEP 21 1920 19 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21st 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16 1920, to Sept 20 1920, that I last saw h W alive on Sept. 20. 1920 and that death occurred, on the date stated above, at 3 1/4 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia Bronchitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J Thaxton Thornton M. D.

19 (Address) 888 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Sept 23rd 1920

20 UNDERTAKER John J Cowan & Son

ADDRESS 901 Hollins St

THIS IS very Important. See Instructions

Spec.—5-19-13—M. & T.—500 Bks.

D 46682

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46682

CERTIFICATE OF DEATH.

40

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 Bentalou ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Thomas McCarron

(Residence in Baltimore: No. 1617 Bentalou St St.: 61 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. April 6th, 1860.
(Month) (Day) (Year)

7-AGE. 60 yrs. 5 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Basket maker 086
(b) General nature of industry, business, or establishment in which employed (or employer). Basket Work

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. William McCarron

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Catherine Waldron

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James D. McCarron

(Address) 1617 Bentalou

15- Filed SEP 21 1920, 191.... ROBERT B KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. September 19th, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 28th 1919, to Sept 19th 1920, that I saw him alive on Sept. 19th 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Structure of Esophagus

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Starvation, Asthenia

(Duration) yrs. mos. 30 ds.

(Signed) Edw Grempton M. D.

9/20, 1920 (Address) 517 Lodtin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cem

DATE OF BURIAL, Sept 22, 1920.

20-UNDERTAKER John Heaman & Son

ADDRESS 924 Fallsway

Spec.—6-9-19—H. P. Co.—1000 Bks.

1946683 HEALTH DEPARTMENT—CITY OF BALTIMORE 1946683

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1511 Baker ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret F. Doyle

(a) RESIDENCE. No. 1511 Baker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 14 - 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 609

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer R. T. Dunn

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Martin Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Annie Lambert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Annie Doyle
(Address) 1511 Baker St

15 Filed SEP 21 1920 ROBERT J. KRAUTER Registrar

THIS IS very important. See instructions on back of this sheet.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1920, to Sept. 20, 1920.

that I last saw h alive on Sept. 20, 1920,

and that death occurred, on the date stated above, at 3:10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. 11 mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms Etc

(Signed) James L. Fotterburger M. D.

(Address) 1777 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Sept 23 1920
20 UNDERTAKER	ADDRESS
Martin Fabert & Sons	847 N Hato

Spec.—6-9-19—H. P. Co.—1000 Bks.

2046684

HEALTH DEPARTMENT—CITY OF BALTIMORE

2046684

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Johnson

(a) RESIDENCE. No. 411 Preston St., ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Captain Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed SEP 21 1920 ROBERT F. BRAUER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 4, 1920, to Sept. 18, 1920.
that I last saw h. im alive on September 18, 1920.
and that death occurred, on the date stated above, at 7:00 A.m.
The CAUSE OF DEATH* was as follows:

Syphilis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilitic aortitis; myocardial insufficiency (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Wassermann.

(Signed) W. H. Eurman M. D.

9-18-1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MT Auburn	Sept 22 1920
20 UNDERTAKER John H. Toadvine	ADDRESS 142 Exeter

HON. is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 46685

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46685

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 Binney ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J. Finnerty

(a) RESIDENCE. No. 1109 Binney ST. 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 19th 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pile Driver

(b) General nature of industry, business, or establishment in which employed (or employer): 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John Finnerty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Margaret Cooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Y.

14 Informant: Margaret Finnerty (Mother)
(Address) 1109 Binney St

15 Filed SEP 21 1920 19 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19th 1920

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1920, to Sept 19, 1920, that I last saw h[illegible] alive on Sept 18, 1920, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 20 mos. ds.

CONTRIBUTORY ~~Syph~~ (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) M. J. McAvoy, M. D.

9/21, 1920 (Address) 8 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Sept. 22nd 1920

20 UNDERTAKER: Lilly & Zeller

ADDRESS 403 S. Wolfe St

TION is very important. See instructions on back of cer

Spec.—8-24-14—M. & T.—2000 Bks.

046686

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 16636

64

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 129 N. Bradford Ave ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ann Crowley

(Residence in Baltimore: No. 129 N. Bradford Ave St.; 50 yrs. mos. de.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, — (Month) — (Day), 1887 (Year)

7-AGE, 66 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Thos Doyle

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Dot Kenn

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Hart

(Address) 129 N. Bradford Ave

15-

Filed SEP 21 1920, 191.... Registrar.

ROBERT F. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep (Month) 20 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sep 17 1920, to Sep 20 1920, that I saw h.er alive on Sep 20 1920, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 1 mos. ds.

Arteriosclerosis

CONTRIBUTORY (Secondary) (Duration) yrs. mos. 4 ds.

(Signed) Louis V. Vogel M. D.

Sep 21, 1920 (Address) 1601 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). In the State yrs. mos. ds.

At place of death yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemetery

DATE OF BURIAL, Sept 23rd, 1920.

20-UNDERTAKER Lilly & Zeiler

ADDRESS 4033 Wolfe St.

A046687 HEALTH DEPARTMENT—CITY OF BALTIMORE A046687

CERTIFICATE OF DEATH.

157

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 40 Hartford Ave. ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Buchmad

(Residence in Baltimore: No. 40 Hartford Ave St.: yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Jan 26 (Month) (Day) 1839 (Year)

7-AGE, 81 yrs. 9 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Cap Maker
(b) General nature of industry, business, or establishment in which employed (or employer), 086

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), cl

12-MAIDEN NAME OF MOTHER cr

13-BIRTHPLACE OF MOTHER (State or Country), cl

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Hunter

(Address) 40 Hartford Ave

15- SEP 21 1920 ROBERT B BEAUTER Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 19 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia, Hanging Suicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(Duration) yrs. mos. ds.

(Signed) Geo Calvin Rhoda M. D. (Coroner.)

9/19/20 (Address) 4316 Gray

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Louden Park Cemetery — DATE OF BURIAL, Sept 22 1920

20-UNDERTAKER Chas Christian Miller — ADDRESS 2334 Jefferson

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

(Dist. Pub.) 698

D 46688

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. Johns Hopkins Hospital ST.: (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ira Peck.

(a) RESIDENCE. NO. Colorado Springs Colorado ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18 - 1877			
7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	43	2	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House wife. 637
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Vermont

PARENTS

10 NAME OF FATHER Charles A Eaton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vermont

12 MAIDEN NAME OF MOTHER Hattie Giddings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Vermont.

14 Informant (Address) J. Hte

15 Filed SEP 21 1920 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1920, to Sept. 21, 1920, that I last saw h[illegible] alive on Sept 21, 1920, and that death occurred, on the date stated above, at 1240 PM.

The CAUSE OF DEATH* was as follows:

Epilepsy / Convulsions

8 yrs. mos. ds.
(duration)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of Sept 17 1920

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. Harrison, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Colorado Springs Col	Sept 22 1920
20 UNDERTAKER	ADDRESS
John O. Mitchell	120 W Kiowa St

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.46689

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.46689

81

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 23 WARD)

2-FULL NAME Mary Allen

(a) RESIDENCE. NO. Unknown 111 N. West ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About ~~Unknown~~	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Unknown~~ Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed SEP 21 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20, 1920

17 I HEREBY CERTIFY, That I attended deceased from September 9, 19..., to September 20, 19 20.

that I last saw her alive on September 19, 19 20.

and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis. (Chronic Nephritis.)
Senile deterioration.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test.

(Signed) W. Herman, M. D.

(Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Sept 22 1920
20 UNDERTAKER K L Pahan	ADDRESS 648 N Lee

THIS is very important. See instructions on the BACK OF CERTIFICATE.

Spec.—8-24-14—M. & T.—2000 Bks.

D.46690

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46690

CERTIFICATE OF DEATH.

151

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West End Maternity ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME (Foetus) of Thompson

(Residence in Baltimore: No. ..... St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M.	White	None

6-DATE OF BIRTH, Sept. (Month) 18 (Day), 1920 (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or 2 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Walter Benson.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Lena Thompson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed....., 191.....

Registrar.

SEP 21 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 18 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 18 1920, to Sept 18 1920, that I saw h.. alive on Sept 18 1920, and that death occurred, on the date stated above, at 10:22 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity birth

6½ months

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) abortion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. D. Hammett M. D.

Sept 21 1920. (Address) 1924 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL. DATE OF BURIAL, SEP 2 1920, 191...

20-UNDERTAKER Per. Wm. E. WOODALL. ADDRESS

Robert F. Garrison, Commissioner of Health

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46691 ✓ D.46691

HEALTH DEPARTMENT—CITY OF BALTIMORE

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4721 Locust Ave 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustav Rauser

(a) RESIDENCE. NO. 4721 Locust Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 40 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced (write the word)~~
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Monika Rauser

6 DATE OF BIRTH (month, day, and year) Aug 18 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Baker

(b) General nature of industry, business, or establishment in which employed (or employer) 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germy

PARENTS

10 NAME OF FATHER Paul Rauser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Catherine Waltz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Monika Rauser

(Address) 4721 Locust Ave

15 Filed SEP 21 1920, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-20 1920

17 I HEREBY CERTIFY, That I attended deceased from June-1, 1920, to Sept. 20, 1920, that I last saw him alive on Sept. 19, 1920, and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

Chron. Arthritis

(duration) 8 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Apoplexy.

(duration) ... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1013 Hillen Baltimore St.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. E. Hoen, M. D.

9-21-20. 19 (Address) 5600 York Road Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cy	Sept 23 1920
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	207 S. Pa

THIS is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.46692 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46692

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4207 Pennhurst St. 28 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Margaret Johnstone

(Residence in Baltimore: No. 4207 Pennhurst Ave St.; 77 yrs., 9 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	W	

6-DATE OF BIRTH, 12 (Month) 8 (Day), 1842 (Year)

7-AGE, 77 yrs. 9 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Gottlieb Engle

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Ann Mary Diemer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Roy Wilson

(Address) 4207 Pennhurst

15-

Filed....., 191.....

Registrar.

SEP 21 1920 Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 20th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 19 1919, to Sept 20 1919, that I saw her alive on Sept 19 1920, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. 1 mos. ds.

(Signed) Benj Om Cleary M. D.

9/20, 1920 (Address) 400 N Paulson St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Greenmount Cem	Sept 22 1920
20-UNDERTAKER Jos Foerstens Son	ADDRESS 217 S. Paca

D.46693 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46693

CERTIFICATE OF DEATH.

X 175-003

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Foot y Scott ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Charlottesville Va

2-FULL NAME George Brice

(Residence in Baltimore: No. 1014 S Eutaw St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Mal	colored	Married

6-DATE OF BIRTH. ? ....., 1.....
(Month) (Day) (Year)

7-AGE. 47 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... B+O R R

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (State or Country), ?

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country), ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mattie Brice

(Address) Charlottesville Va

15-

Filed SEP 21 1920, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

Steam R.R. accident

(Duration) ..... yrs. Instant ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Benton M. D.
(Coroner.)

Sept 21, 1920 (Address) 705 E Clay St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....
Foot & Scott St

Former or usual residence 1014 S Eutaw St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Charlottesville Va	9-21-..., 1920
20-UNDERTAKER	ADDRESS 17 S
Robt W Brooks & Son	Calhoun St

CAUSE OF DEATH to be filled in plainly and completely. Every question important. See instructions on back of certificate.

D. 46694

HEALTH DEPARTMENT--CITY OF BALTIMORE

D. 46694

CERTIFICATE OF DEATH

X 100-001

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 904 McCulloh ST. 11 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Robert Ford

(Residence in Baltimore: No. 904 McCulloh St.; yrs. 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Sept ? (Month) (Day), 1913 (Year)

7 AGE: 7 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9 BIRTHPLACE (State or country): Tenllytown Va

PARENTS

10 NAME OF FATHER: Frank Ford

11 BIRTHPLACE OF FATHER (State or country): Va

12 MAIDEN NAME OF MOTHER: Annie Teges

13 BIRTHPLACE OF MOTHER (State or country): Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Ford

(Address) 904 McCulloh

15 Filed SEP 21 1920, 191 Robert P. Harrison, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 9 (Month) 21 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18, 1920, to Sept 21 1920, that I saw h[illegible] alive on Sept 20 1920, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(Duration) yrs. 2 mos. ds

Contributory (SECONDARY) Pneumonia, arteriosclerosis.

(Duration) yrs. 9 mos. ds.

(Signed) Harry D McCarty M. D.

Sept 21, 1920 (Address) 37 W Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Tenllytown Va — DATE OF BURIAL: Sept 22, 1920

20 UNDERTAKER: Samuel S Hemsley — ADDRESS: 578 N Bond

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.46695

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D.46695

80

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 3619 Springdale Ave ST.; 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Johanna Hecht

(Residence in Baltimore: No. 3619 Springdale Ave St.; Lifetime yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: March 22, 1861 (Month) (Day) (Year)

7 AGE: 59 yrs. 5 mos. 28 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Home Work
(b) General nature of industry, business, or establishment in which employed (or employer): .....
037

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: August Lenz

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Johanna

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adolph H Hecht

(Address) 3619 Springdale Ave

15.

Filed ....., 191.....

Robert P. Harrison, REGISTRAR

SEP 21 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 20th, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/2, 1920, to 9/20 1920 that I saw h[illegible] alive on 9/20, 1920, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

..... (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Arteriosclerosis.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Arthur H Schaupeck M. D.

9/21, 1920 (Address) 2506 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: London Park Cem

DATE OF BURIAL: Sept 22, 1920

20 UNDERTAKER: H. Allen Fuller

ADDRESS: 3517 Springdale Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Levandowski

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46696

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D46696

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 722 S. Regester ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Levandowski

(a) RESIDENCE. NO. 722 S Regester ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 7 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Lewandoski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Eva De Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S Carolina

14 Informant (Address) Josep Lewandoski 722 S Regester

15 Filed SEP 22 1920 19 BOARD OF HEALTH Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Sep 7, 1920, to Sep 20, 1920, that I last saw h alive on Sep 20, 1920, and that death occurred, on the date stated above, at 8 p.m.

The CAUSE OF DEATH* was as follows:

Congenital Weakness
(Premature Infant)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Weston M. D.

Sep 22, 1920 (Address) 16 W Read

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary Trappe Rd.	Sep 22 1920
20 UNDERTAKER	ADDRESS
Wendell Dippel & Son	378 Mn

TION is very important. See instructions on back of

D46697

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 D 46697

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No Henry B. Coulson St. 15 WARD)

2 FULL NAME 3210 Walbrook Ave

(Residence in Baltimore: No. 3210 Walbrook Ave St.; 60 yrs. mos. ds.)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED ~~WIDOWED~~ OR DIVORCED (Write the word): married

6 DATE OF BIRTH: nov 9th, 1849 (Month) (Day) (Year)

7 AGE: 70 yrs. 10 mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: AC Consultant
(b) General nature of industry, business, or establishment in which employed (or employer): Dr

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Wm H. Coulson

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary H. Broughton

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma V. Coulson

(Address) 3210 Walbrook Ave

15 Filed SEP 22 1920 ROBERT B KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 20th, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20th, 1920, to, Sept 20th 1920, that I saw h~~e~~ alive on Sept 20th, 1920, and that death occurred, on the date stated above, at 8.30A m. The CAUSE OF DEATH* was as follows:

Hemoplegia

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) General Paralysis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Herbert E. Gelb M. D.

Sept 21, 1920 (Address) 30 So. St. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Druid Ridge — DATE OF BURIAL: Sept 22, 1920

20 UNDERTAKER: John Owings — ADDRESS: Mt Royal

N. B.—Every item must be answered, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

046698

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 046698

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4111 Waldrad ave ~~St.~~ 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Holston

(a) RESIDENCE. NO. St. Helena, Baltimore ~~St.~~ WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mrs. Lucinda Holston

6 DATE OF BIRTH (month, day, and year) March 12, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John C Holstry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Red Pa.

12 MAIDEN NAME OF MOTHER Rebecca Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co.

14 Informant Lucinda Holston.
(Address) St Helena Balto co

15 Filed SEP 22 1920, 19 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20- 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1920, to Sept 20, 1920, that I last saw him alive on Sept. 20, 1920, and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatus Nephritus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H C. Pettelson, M. D.

, 19 (Address) 817 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: 9-22- 1920

20 UNDERTAKER: Robert Brooks & Son — ADDRESS 175 Calhoun st

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Piemann)

D.46699

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46699

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 214 E Chase ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME — Gertrude Margaret Piemann

(a) RESIDENCE. NO. 214 E Chase ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 25-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Piemann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Myrtle Ritchie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Myrtle Piemann

(Address) 214 E. Chase on

15 Filed SEP 21 1920, 19.....

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1920, to Sept 20, 1920, that I last saw her alive on Sept 20, 1920, and that death occurred, on the date stated above, at 3.55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Wheelan M. D

Sept. 1920 (Address) 209 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Cemetery	Sept 21 1920
20 UNDERTAKER	ADDRESS
F. H. Ivanes & Son	737 Hanover

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

046700 REGISTERED NO. 79

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO. 423 S. Paca ST.: 22 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman H. Heer,

(a) RESIDENCE. NO. 423 S. Paca ST., 22 WARD.
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hedwig Heer.

6 DATE OF BIRTH (month, day, and year) March 19, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	6	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS
10 NAME OF FATHER Henry J. Heer
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.
12 MAIDEN NAME OF MOTHER Elise Buchman
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) Hedwig H. Heer. 423. S. Paca. St.

15 Filed SEP 22 1920 ROBERT B. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21 1920

17 I HEREBY CERTIFY, That I attended deceased from August 31, 1920, to Sept 21, 1920, that I last saw h.. alive on Sept. 21, 1920; and that death occurred, on the date stated above, at 11.50 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 3 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) J M Dalrett, M. D.
Sept 21, 1920 (Address) 621 Columbia Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem.
DATE OF BURIAL Sept 23 1920
20 UNDERTAKER John Wrobliauskas
ADDRESS 425. S. Paca St.

(See instructions on back of certificates. ATION is very important.)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46701

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46701

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 S Eleventh ST.: 25 WARD)

2-FULL NAME Mary B. Crumbacker

(a) RESIDENCE. No. 3 S Eleventh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. D. Crumbacker

6 DATE OF BIRTH (month, day, and year) May 10 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Oplhaus Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Wm. D. Crumbacker

(Address) No 3 S. Eleventh St.

15 Filed ..... 19 ROBERT B. LATIMER Registrar

SEP 22 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1920, to Sept. 20, 1920, that I last saw her alive on Sept. 20, 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Frank A. Glendenning M. D.

, 19 (Address) 3244 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Sept 23 1920
20 UNDERTAKER Henry Hoeck & Son	ADDRESS 1301 E Eager St.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1946702

HEALTH DEPARTMENT—CITY OF BALTIMORE

1946702

CERTIFICATE OF DEATH.

1720

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2739 Eastern Ave ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Albert Miller.

(a) RESIDENCE. NO. 2739 Eastern Ave ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 11 mos. 26 ds. How long in U. S., if of foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (~~or Wife of~~) Elizabeth M. Miller

6 DATE OF BIRTH (month, day, and year) Oct. 16. 1887.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician 054

(b) General nature of industry, business, or establishment in which employed (or employer) .

(c) Name of employer .

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Chas. C. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Virginia Schuler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Elizabeth M. Miller (Address) 2739 Eastern Ave.

15 Filed SEP 22 1920 ROBERT F KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1920, to Sept 20, 1920, that I last saw h~~im~~ alive on Aug 20, 1920, and that death occurred, on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Interstitial nephritis

(duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? In Brooklyn

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary

(Signed) C Urban Smith, M. D.

, 19 (Address) 817 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 24 1920
20 UNDERTAKER	ADDRESS
Zirkler & Zirkler	1739 E. Eager St.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0946703

HEALTH DEPARTMENT—CITY OF BALTIMORE

0946703

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. O'Donnell + 24th St. ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Stromer.

(a) RESIDENCE. NO. O'Donnell + 24th St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 11 mos. 1 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ Mary Stromer

6 DATE OF BIRTH (month, day, and year) Oct. 20-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry Stromer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mary Stromer (Address) O'Donnell + 24th St.

15 Filed SEP 22 1920 ROBERT E KRAUTER Registrar

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1920

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1920, to Sept 21, 1920, that I last saw him alive on Sept 21, 1920, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach (Pylorus) (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos McAvoy, M. D.

9/22, 1920 (Address) 836 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Sept. 22 1920
20 UNDERTAKER Zirkler + Zirkler	ADDRESS 1739 E. Eager St

TION is very important. See instructions on back of

Spec.—8-24-14—M. & T.—2000 Blks.

1946704 HEALTH DEPARTMENT—CITY OF BALTIMORE 1946704

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 1503 Riviera Av ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Davis

(Residence in Baltimore: No. 1503 Riviera Av. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: July 17, 1845 (Month) (Day) (Year)

7-AGE: 75 yrs. 2 mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Own

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: John Davis

11-BIRTHPLACE OF FATHER (State or Country): Balto. Md

12-MAIDEN NAME OF MOTHER: Ann M. Buck

13-BIRTHPLACE OF MOTHER (State or Country): Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. Davis

(Address) 1503 Riverside Ave

15- SEP 22 1920 Filed....., 191.... ROBERT E KRAUTER Burial Permit Clerk Registrar.

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 20, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1919, to Sept. 20 1920, that I saw him alive on Sept 20 1920, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

1. .....
2. Chron. Interst. Nephritis
3. Con. Kidney (Duration) about 9 mos. ds.

CONTRIBUTORY (Secondary) Uraemic Coma (Duration) ... yrs. ... mos. 3 ds.

(Signed) Robt E. C. Schmidt M. D.

Sept 21, 1920 (Address) 1318 E. Pleasant St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Sept 23, 1920
20-UNDERTAKER	ADDRESS
E. J. Fanning & Son	1440 Battery Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46705 HEALTH DEPARTMENT—CITY OF BALTIMORE D46705

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 1504 N Washington ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Bollman

(a) RESIDENCE. No. 1504 N Washington ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 28, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ferd. Knaus.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Nat Knaus.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm Dachse

(Address) 1504 N Washington

15 Filed SEP 22 1920 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19. 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1920, to Sept. 19, 1920, that I last saw h[illegible] alive on Sept. 18. 1920, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 2 Elsinore Rd

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis of arm & leg

(Signed) Gustav H. Baltzell, M. D.

Sept. 19 20 (Address) 1310 Guilford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 22 1920
20 UNDERTAKER	ADDRESS
E J Janney & Son	1038 E Lafayette

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46706

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46706

CERTIFICATE OF DEATH.

108

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1525 N. Dallas ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Pitts

(a) RESIDENCE. NO. 1525 N. Dallas ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon Pitts

6 DATE OF BIRTH (month, day, and year) June 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) general housework

(c) Name of employer at home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) U.S.A.

12 MAIDEN NAME OF MOTHER Susan Rhodes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Staunton Va

14 Informant Simon Pitts

(Address) 1525 N. Dallas St.

15 Filed SEP 22 1920 ROBERT E. CRATTY Registrar

Burial Permit Clerk

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1920, to Sept. 20, 1920, that I last saw h— alive on Sept. 19, 1920, and that death occurred, on the date stated above, at 5:45 p.m.

The CAUSE OF DEATH* was as follows: Acute suppurative appendicitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Intestinal catarrh?

(duration) yrs. — mos. ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. C. Stevenson, M. D.

19 (Address) 520 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Sept 22 1920

20 UNDERTAKER Samuel Hensley

ADDRESS 578 N. Eden

D46707

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

154 D46707

1-PLACE OF DEATH — Registered No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. 1320 W Lexington St. 19 WARD)

2-FULL NAME Mary Jane Price

(Residence in Baltimore: No. 1320 W Lexington St.; 40+ yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
7	W	Single

6-DATE OF BIRTH May (Month) 15 (Day), 1833 (Year)

7-AGE 87 yrs. 4 mos. 6 ds. — If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE (State or country) Baltimore Co

PARENTS

10-NAME OF FATHER Benj. R. Price

11-BIRTHPLACE OF FATHER (State or country) Balto Co

12-MAIDEN NAME OF MOTHER Ann M. Matthews

13-BIRTHPLACE OF MOTHER (State or country) Balto Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Katherine E. Price

(Address) 1320 W Lexington St

15. Rec'd SEP 22 1920 ROBERT B. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept (Month) 21 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5, 1920, to Sept 20 1920

that I saw h[illegible] alive on Sept 20, 1920.

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

General debility

(Duration) yrs. 5 mos. ds

Contributory (SECONDARY) Exhaustion

(Duration) yrs. 1 mos. ds.

(Signed) Barnett C. Cattin M. D.

Sept 21, 1920 (Address) 1404 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Friends Meeting Md — DATE OF BURIAL Sept 23 1920

20-UNDERTAKER W. C. Brooks — ADDRESS Sparks Md

N. B.—Every question must be answered so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. State CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

D46708

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46708

CERTIFICATE OF DEATH.

x 30

1-PLACE OF DEATH Church Home and Infirmary

REGISTERED NO. C

CITY OF BALTIMORE: (No. Broadway & Fairmount Ave ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Shertzer

(Residence in Baltimore: No. 705 East E St, Sparrows Point, Md. St.; ..... yrs., ... mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1878 (Year)

7-AGE, 42 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Iron Worker
(b) General nature of industry, business, or establishment in which employed (or employer) Sparrows Pt

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Isaac S Kutzer

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Mary Price

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaac S Kutzer

(Address) 720 E F St Sparrows Pt

15-

Filed SEP 22 1920, 191...

ROBERT B KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 18, 1920, to Sept. 21, 1920, that I saw h[im] alive on Sept. 21, 1920, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:-

Tuberculosis Meningitis

..... (Duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Walter L. Anderson M. D.

Sept 21, 1920. (Address) Church Home & Inf.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 17 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Sparrows Pt, Md.

Former or usual residance 705 East E St. Sparrows Pt, Md.

19-PLACE OF BURIAL OR REMOVAL Sparrows Point Md DATE OF BURIAL Sept 24 1920

20-UNDERTAKER H. C. Brooks ADDRESS Essex, Md

Spec.—8-24-14—M. & T.—2000 Bks.

D46709

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46709

CERTIFICATE OF DEATH.

138

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Nannie Roberta Shipley Price

(Residence in Baltimore: No. Sparks, Balto. Co. Md. St.; 34 yrs., 6 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. March 13, 1886
(Month) (Day) (Year)

7-AGE. 34 yrs. 6 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). 0

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, J. F. Shipley.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Anna Murphy

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank DeWorken Stone

(Address) Women's Hospital.

15-

SEP 22 1920

Filed....., 191.....

ROBERT E. LAZA... Burial Permit

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 20 1920, to Sept 21 1920, that I saw h.. alive on Sept. 21, 1920, and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration).....yrs.....mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Frank DeWorken Stone M. D.

Sept 21, 1920 (Address) Women's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. 1 ds. In the State 34 yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? Sparks, Md

Former or usual residence Sparks, Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Rush Cemetery Govans	Sept 23 1920
20-UNDERTAKER	ADDRESS
J. Elmer Burns Sons	Towson

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D46710

D46710

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1329 Mosher ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Andrew Pate

(a) RESIDENCE. NO. 1324 Mosher ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Griffith (Pate)

6 DATE OF BIRTH (month, day, and year)				
7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	43	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Miner

(b) General nature of industry, business, or establishment in which employed (or employer) Mining

(c) Name of employer Nat Lufton

9 BIRTHPLACE (city or town) (State or country) Rockingham, N. C.

PARENTS

10 NAME OF FATHER Wm B. Pate

11 BIRTHPLACE OF FATHER (city or town) Halifax (State or country) Virginia

12 MAIDEN NAME OF MOTHER Caroline Delaney

13 BIRTHPLACE OF MOTHER (city or town) Rockingham (State or country) N. C.

14 Informant Mrs. Carlana Pate (Address) 324 Mosher St.

15 Filed SEP 22 1920 19 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21st 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 17th, 1920, to Sept 21st, 1920, that I last saw h[illegible] alive on Sept 20th, 1920, and that death occurred, on the date stated above, at 6:15 A. m

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? West Virginia

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Smear Positive

(Signed) Jas Earl Ball M. D.

, 19 (Address) 1515 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Sept 23 1920

20 UNDERTAKER Chas H Sra — ADDRESS 1400 Mosher

TION is very important. See instructions on back of certificates.

D 46711 HEALTH DEPARTMENT—CITY OF BALTIMORE 150 D 46711

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1094 N Front St.) 10 WARD) REGISTERED No. C.....

2-FULL NAME Mary Kearns

(Residence in Baltimore: No. 1894 N Front St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. September 3rd, 1920
(Month) (Day) (Year)

7-AGE. ....yrs. ....mos. 18 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... nil

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Dont know

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER Clara Kearns

13-BIRTHPLACE OF MOTHER (State or Country). Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Kearns

(Address) 1094 N Front St

15- SEP 22 1920 ROBERT B BEAUTER

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: (

Asphyxia Fluida

(Duration) ....yrs. ....mos. 1 ....ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) ....yrs. 1 mos. ....ds.

(Signed) H. S. Klumpp (Coroner.) M. D.

9/21, 191.. (Address) 1427 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemetery
DATE OF BURIAL, Sept 22 1920

20-UNDERTAKER George Sohulledge & Sons
ADDRESS Monument & Aisquith

CAUSE OF DEATH. This line for the primary cause is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D46712 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D46712

CERTIFICATE OF DEATH.

146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3011 St Paul ST.; 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Edwina Bregenzer

(Residence in Baltimore: No. 3011 St Paul St.; 43 yrs., 6 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, March (Month) 16 (Day), 1877 (Year)

7-AGE, 43 yrs. 6 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clergyman
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Maryland

PARENTS.

10-NAME OF FATHER, Charles A. Bregenzer

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Maryland

12-MAIDEN NAME OF MOTHER Elizabeth Klinesmith

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Anna G. Bregenzer

(Address) 3011 St. Paul Street

15-

Filed SEP 22 1920 191.... ROBERT F. LAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 20 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1920, to Sept 20 1920, that I saw h[illegible] alive on Sept 20 1920, and that death occurred, on the date stated above, at 1140 P m.

The CAUSE OF DEATH* was as follows:

Coma Cerebral Lesion

(Duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Anaemia

(Duration) yrs. mos. ds.

(Signed) W. D. Lashley M. D.

9.21, 1920 (Address) 711 W. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	9/23, 1920
20-UNDERTAKER Henry W. Mears & Son	ADDRESS 305 N. Calvert

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

046713 HEALTH DEPARTMENT—CITY OF BALTIMORE V 046713

CERTIFICATE OF DEATH.

1-PLACE OF DEATH REGISTERED NO. C 151

CITY OF BALTIMORE: (No. Main St. Hillsdale St. 38th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby. Harding

(Residence in Baltimore: No. Main St. Hillsdale St. St.; yrs., 4 hours mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write this word.) ~~Married~~

6-DATE OF BIRTH, Sept 21, 1920 (Month) (Day) (Year)

7-AGE, ~~yrs.~~ ~~mos.~~ ~~ds.~~ 4 hours

If LESS than 1 day, 4 hrs. ~~Or ... min.~~

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Hillsdale Balto

PARENTS.

10-NAME OF FATHER, Joseph Gilroy

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Elsie Harding

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elsie Harding

(Address) Hillsdale Baltimore Md

15- SEP 22 1920 ROBERT F KRAUTER

Filed ..., 191.. Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 21, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 21 1920, to Sept 21 1920, that I saw h[illegible] alive on Sept 21 1920, and that death occurred, on the date stated above, at 3.15 p.m.

The CAUSE OF DEATH* was as follows: Baby was not full term. Highly ateiv [illegible] only lived 4 hours.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Birth

(Duration) yrs. mos. ds.

(Signed) Geo F Everhart M. D.

Sept 22, 1920 (Address) Woodlawn Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Thistle Cem Balto Co

DATE OF BURIAL, Sept 22, 1920

20-UNDERTAKER Easton Sons

ADDRESS Ellicott City

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L046714

HEALTH DEPARTMENT—CITY OF BALTIMORE

L046714

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 N Kenwood ST.; 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Collern

(a) RESIDENCE. No. 208 N Kenwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9th 20

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frank Seyffeth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Estella Collern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Frank Synder

(Address) 208 N Kenwood Ave

15 Filed SEP 22 1920 ROBERT F KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Sept 22 1920,

that I last saw him alive on Sept 21, 1920,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

General Gonococcal Infection
Of Asthenic Constitution

(duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) Inanition

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Lloyd M. D.

9/22 1920 (Address) 875 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Sept 22 1920
20 UNDERTAKER Philip Herwig	ADDRESS 206 Orleans St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46715

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46715

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Vincents Infant ~~Asylum~~ Hospital WARD)

2-FULL NAME Teresa McGraw

(a) RESIDENCE. NO. St. Vincents Infant Asylum WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Femal	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 1 1920

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William McGraw

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Margrit Ruppert

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant S. W. Mathews
(Address) St Vincent Asylum

15 Filed SEP 22 1920 ROBERT F. [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 17, 1920, to Sept 20, 1920, that I last saw her alive on Sept. 20, 1920, and that death occurred, on the date stated above, at 2 A' m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Icterus Celetes 3 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Chas H Slagle, M. D.

Sept 22, 1920 (Address) 1504 McCulloh St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	9/22/20

20 UNDERTAKER H. C. Friedfeld ADDRESS 919 Gunmount.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations may be used if necessary. Fill in all items if possible. Physician's address is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1946716 — 1946716

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. ..... St.: 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hardman #2

(a) RESIDENCE. No. ..... St., ... Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9/17/20

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	—	—	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER George Barber ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Nettie Hardman

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Maryland

14 Informant Dr. E. L. Stone
(Address) JOHNS HOPKINS HOSPITAL.

15 Filed SEP 22 1920 19 ROBERT J. [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/18/ 1920

17 I HEREBY CERTIFY, That I attended deceased from 9/17/, 1920, to 9/18/, 1920,
that I last saw him alive on 9/18/, 1920,
and that death occurred, on the date stated above, at 1.50 P m.
The CAUSE OF DEATH* was as follows:
Hemorrhagic disease of the New Born.

(duration) 0 yrs. 0 mos. 1 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of 9/18/20 (Transfusion)
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E. L. Stone, M. D.
, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL.	SEP 22 1920

20 UNDERTAKER Commissioner Health.
ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46717 1920 26

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46717

CERTIFICATE OF DEATH.

45 1864

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 207 N Rine St ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie B Garrett

(a) RESIDENCE. No. 207 N Rine St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Garrett

6 DATE OF BIRTH (month, day, and year) Mar 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Francis Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lucien L Tennick

(Address) 207 N Rine St

15 Filed SEP 22 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 20th 1920

17

I HEREBY CERTIFY, That I attended deceased from June 10th, 1920, to September 20th, 1920, that I last saw him alive on September 19, 1920, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Cancer of the Bladder

(duration) 1 yrs 2 mos 10 ds

CONTRIBUTORY (Secondary) Starvation

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Yes

(Signed) Frank H Yeomans, M. D.

Sept 22 1920 (Address) 322 N Greene St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Sept 23rd 1920
20 UNDERTAKER	ADDRESS
Hammett & Wisfield	1364 N Carey St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.46718 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46718

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.: 13th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Sample

(a) RESIDENCE. No. 313 Forest St ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2 - 1920

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Colored. ppd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Nelson Williams

11 BIRTHPLACE OF FATHER (city or town)
(State or country) West Indies

12 MAIDEN NAME OF MOTHER Eva Sample

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Hospital Record
(Address) J. H. H.

15 Filed SEP 22 1920 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1920, to Sept. 20, 1920, that I last saw him alive on Sept. 20, 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Diarrhoea
Not dysentery

(duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Culture & Autopsy

(Signed) W. E. Dawson M. D.

, 19 (Address) J H H Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Sept. 22 1920
20 UNDERTAKER	ADDRESS
Wm J. G. Locks	1302 Jefferson

CAUSE OF DEATH must be plainly stated. Use no abbreviations or terms. Do not report symptoms, but the disease causing death. Indefinite or incomplete answers cannot be accepted. Write plainly with pen and ink. Fill in all blanks with the information desired or the word "unknown" or the answer "none," as the case may be. PENALTY for failure to report any death, or for reporting any false information, is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46719 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46719

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 N Castle ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Pfannkuchen.

(a) RESIDENCE. NO. 616 N Castle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Pfannkuchen

6 DATE OF BIRTH (month, day and year) Apr 1 - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Kratz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Geppers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Conrad Schmidt

(Address) 616 N Castle

Filed SEP 22 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1920

17 I HEREBY CERTIFY, That I attended deceased from September, 19 19 to Sept. 20, 19 20, that I last saw h[illegible] alive on Sept 20 19 20, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? bacteriological

(Signed) Edward Novak, M. D.

19 (Address) 821 N. Patt. Pk. Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery

DATE OF BURIAL: Sept 23 1920

20 UNDERTAKER: J Herwig & C

ADDRESS: 2008 Eutaw

CAUSE OF DEATH is plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.46720 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46720

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ward McHugh

(a) RESIDENCE. NO. Roanoke Va " ST.. .... WARD. —

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 0 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married -

5a If married, widowed, or divorced (or) WIFE of T. A. McHugh.

6 DATE OF BIRTH (month, day, and year) ? 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42 yrs abt	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER Frank Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Biloxi Miss

12 MAIDEN NAME OF MOTHER Lucy Denny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norfolk Va

14 Informant Records of Mt Hope Retreat

(Address) Mt Hope Balto Md.

15 Filed SEP 22 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1920

17

I HEREBY CERTIFY, That I attended deceased from March 25 , 1913, to Sept 21 , 1920,

that I last saw h alive on Sept. 20 , 1920,

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Bowels -

(duration 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Paranoia

abt (duration) 17 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Roanoke Va

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk- Va "	Sept 22 1920

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM T. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. [illegible] on back of certificates.

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

20.46721

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.46721

CERTIFICATE OF DEATH.

105

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 N. Eden St ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Everett Chester

(Residence in Baltimore: No. 712 N. Eden St St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col.	Single

6-DATE OF BIRTH, Sept 1 (Month) 23 (Day), 1917 (Year)

7-AGE, 3 ....yrs.....mos.....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Nil
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Norman Chester

11-BIRTHPLACE OF FATHER (State or Country), Balto, Md.

12-MAIDEN NAME OF MOTHER Rebecca Hall

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Norman Chester

(Address) 712 N. Eden St.

15-

Robert P. Harrison,

Filed....., 191.....

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 1 (Month) 20 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 20 | 9 | 1920, to 7 | 9 | 191..., that I saw h.. alive on 7 | 9 | 1920, and that death occurred, on the date stated above, at 10.30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) 11 yrs. 11 mos. one ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) yrs. mos. ds.

(Signed) E. Mayfield Boyle M. D.

2 | 9 | 1920 (Address) 422 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel	Sept 23, 1920
20-UNDERTAKER John E. Henderson & Monument	ADDRESS 1602

Important. See instructions on back of certificate.

D.46722 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46722

CERTIFICATE OF DEATH.

120

REGISTERED No. C.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 931 Shields Place ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Henry Richardson

(Residence in Baltimore: No. 931 Shields Place. St.: 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	colored	widower

6-DATE OF BIRTH. March 20, 1865. (Month) (Day) (Year)

7-AGE. 65 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): Farming

9-BIRTHPLACE. (State or Country): Virginia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Zedick Wainwright

(Address) 931 Shields Place

15- Robert P. Harrison,

Filed SEP 22 1920, 191 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept. 19, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1. Chronic Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Organic Heart disease

(Duration) 1 yrs. mos. ds.

(Signed) J. H. Hennessy M. D. (Coroner.)

Sept. 20, 1920 (Address) 2302 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	Sept 22, 1920

20-UNDERTAKER	ADDRESS
Daniel Easton	[illegible]

NOTE.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.46723 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46723

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 640 Green Mellon ST.: 17 WARD) 150

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis Briscoe

(Residence in Baltimore: No. 640 Green Mellon St.: yrs., mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	Colored	Single

6-DATE OF BIRTH, Sept. 1, 1920
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
.....yrs. 20 mos. 20 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles Briscoe

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Louise Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Louise Briscoe

(Address) 640 Green Mellon

15- Robert P. Harrison,

Filed SEP 22 1920, 191.....

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration).....yrs.....mos. 20 ds.

CONTRIBUTORY (Secondary) No History

(Duration).....yrs.....mos.....ds.

(Signed) J. S. Hennessy M. D.
(Coroner.)

Sept 21, 1920 (Address) 1502 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Sept 23, 1920
20-UNDERTAKER Daniel Easton	ADDRESS 916 Old

N.B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D.46724 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46724

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 Lennox ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irma Mohler Codd

(a) RESIDENCE. NO. 702 Lennox ST., 13 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? 57 yrs. 10 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of William C. Codd

6 DATE OF BIRTH (month, day, and year) November 14 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER Isaac H. Mohler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER Julia Larsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Wm J. Early Codd (son)

(Address): 702 Lennox St.

15 Filed SEP 22 1920 19

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21st 1920

17 I HEREBY CERTIFY, That I attended deceased from May 31st, 1920, to Sept 21st, 1920, that I last saw her alive on Sept 21st, 1920, and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Chronic Bright's Disease

(duration) 10 Yrs. Probably mos. ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. Hampson Jones, M. D.

, 19 (Address) 2529 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Sept 24/ 1920
20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS: 108 W. NORTH AVE.

mation should be carefully inquired. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.46725 ✓ D.46725

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 Argyle ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Brown

(Residence in Baltimore: No. see above St.: 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, Col | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Aug 25 (Month) (Day), 1877 (Year)

7-AGE, 43 yrs. 1 mos. ..... ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Deals Island Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mertrosa Brown

(Address) 919 argyle ave

15- SEP 22 1920 Filed ....., 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) – 21 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9-15-20 191..., to 9-21-20 191..., that I saw h[illegible] alive on ..." 191..., and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

From chr Pneumonia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exposure & debility

(Duration) ....yrs. 1/2 mos. ....ds.

(Signed) H. Candler M. D.

9-21-20, 191... (Address) 1524 N. Hill ave,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? " " "

Former or usual residence "

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn | DATE OF BURIAL, Sept 24/1920

20-UNDERTAKER John H. Toadvine | ADDRESS 142 Ostend St

Keep this certificate clean. Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46726 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46726

CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Diggs.

(a) RESIDENCE. No. St Leonard Calvert Co, ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
58				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER James Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Martha Cross.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John Diggs (Address) Calvert Co. Md

15 FILED SEP 22 1920 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1920.

17 I HEREBY CERTIFY, That I attended deceased from Sept 2 1920, to Sept 22 1920; that I last saw h-e alive on Sept 22 1920, and that death occurred, on the date stated above, at 1 30 a m.

The CAUSE OF DEATH* was as follows:

Cardiac failure.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Malignancy Uni

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no. Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) J. O. Ridgely, M. D

19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Governors Run Calvert Co Md	Sept 23 1920
20 UNDERTAKER John H. Bradnum	ADDRESS 172 Uthrich St

D.46727

HEALTH DEPARTMENT---CITY OF BALTIMORE

D.46727

CERTIFICATE OF DEATH

79

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 243 N. Woodland Ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Oliver Lumley

(Residence in Baltimore: No. 243 N Woodland ST. 27 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: June (Month) 15 (Day) 1846 (Year)

7-AGE: 74 yrs. 2 mos. ds. — If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Lumber
(b) General nature of industry, business, or establishment in which employed (or employer): Marker

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: Frederick Lumley

11-BIRTHPLACE OF FATHER (State or country): Balto Md

12-MAIDEN NAME OF MOTHER: Susan Duck

13-BIRTHPLACE OF MOTHER (State or country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miller A. Lumley

(Address) 2434 Woodland Ave

15- Robert P. Harrison,

Filed SEP 22 1920 191. Burial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Sept (Month) 20 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 14, 1920, to, Sept 20 1920, that I saw h[illegible] alive on Sept 20 1920, and that death occurred, on the date stated above, at 5.55 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) ..... yrs ..... mos. ..... ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs ..... mos. ..... ds.

(Signed) John D Bulbert M. D.

Sept 20 1920 [Address] 1884 Park Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: Sept 16 1920

20-UNDERTAKER: Wm Cook — ADDRESS: 5026 E Northern

state CAUSE OF DEATH in plain terms, so that it may be properly classified. [illegible] statement of occupa-
TION is very important. See instructions on back of certificate.

D.46728 HEALTH DEPARTMENT--CITY OF BALTIMORE D.46728

CERTIFICATE OF DEATH.

904

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 570 S. Milton Av ST.; 1 WARD) REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Loretta A Bunch

(Residence in Baltimore: No. 570 S. Milton Av St.; Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	

6-DATE OF BIRTH, Jan 10 (Month) (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
yrs. 8 mos. ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Wm. Bunch

11-BIRTHPLACE OF FATHER (State or Country). Balto - Md.

12-MAIDEN NAME OF MOTHER Mary Beck

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) May Bunch

(Address) 570 S. Milton Ave.

15-

SEP 22 1920 Filed, 191 Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 21 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. ds.

(Signed) Wm Ellis Cooley M. D.
(Coroner.)

9/21/1920 (Address) 145 N. Bond

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	Sept 23 1920
20-UNDERTAKER William Cook	ADDRESS 502 E. Mott Ave

N.B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46729 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46729

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 619 S Bond ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Kruzborski

(a) RESIDENCE. NO. 619 S Bond ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6/20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Kruzborski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Bronislawa Bielczynska

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Bronislawa Kruzborska
(Address) 619 S Bond St

15 Filed SEP 22 1920 16 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/22 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1920, to Sept 22, 1920, that I last saw her alive on Sept 21 st, 1920, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Anthemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jay D Bradley, M. D.

, 1926 (Address) 1623 E Pratt ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	SEP 23 1920
20 UNDERTAKER M. F. Sulinski	ADDRESS 705 S Ann St

CAUSE OF DEATH to be filled in plainly, so that words may be read in any part of certificates. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046730

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046730

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Bessemer Ave Gradand Pk (ST.) 26 (WARD)

2-FULL NAME William Thomas Gardiner

(a) RESIDENCE. NO. Bessemer Ave Gradand Pk WARD.....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) — None

(c) Name of employer — None

9 BIRTHPLACE (city or town) (State or country) — Balto.

PARENTS

10 NAME OF FATHER Wm C. Gardiner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary M Story

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm C Gardiner
(Address) Gradland Park

15 Filed SEP 23 1920 19 ROBERT F FRAZIER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 21 1920, to Sept 22 1920, that I last saw him alive on Sept 22 1920, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

7th mo Gestation

Born 15 ds.

CONTRIBUTORY (Secondary) Premature Birth (duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) F. Ed. Hesser, M. D

Sept 22 1920 Address) 1301 Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dalto Cemetery	Sept 23 1920
20 UNDERTAKER Robt J Turner	ADDRESS 1424 Pa Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46731 HEALTH DEPARTMENT—CITY OF BALTIMORE D46731

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH St Vincent Inf asylum REGISTERED NO.

CITY OF BALTIMORE: (No. 1401 Druid St. ST.: 14 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Francis Cantow
St Vincent asylum

(a) RESIDENCE. NO. 1401 Druid ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Mary Antoni

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant S. W. Mathews
(Address) St. Vincents Infant Asyl.

15 Filed SEP 23 1920 19 ROBERT I. KRAETER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1920, to Sept. 19, 1920, that I last saw him alive on Sept 19, 1920, and that death occurred, on the date stated above, at 12:45 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? New York

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. F. Claudius M. D.

Sept 20, 1920 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Sept 23 1920

20 UNDERTAKER Martin Father & Sons ADDRESS 827 N Fulton Ave

Spec.—8-24-14—M. & T.—2000 Bks.

Louis C. Schwartz

D46732

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46732

CERTIFICATE OF DEATH.

15

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 608 Harwood Ave St.; 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis C. Schwartz (Use Middle Name)

(Residence in Baltimore: No. 608 Harwood St.; ...yrs., ...mos., ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept. 22, 1920
(Month) (Day) (Year)

7-AGE, Breathed twice. yrs. mos. ds. If LESS than 1 day, hrs. or 2 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), 608 Harwood Ave

PARENTS.

10-NAME OF FATHER, John Louis Schwartz

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Elizabeth Trautte

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Schwartz

(Address) 608 N. Harwood Ave

15-

Filed SEP 23 1920 ROBERT E KRAUTER Registrar.

BUREAU VITAL STATS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 22, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 22 1920, to Sept 22 1920, that I saw him alive on Sept 22 1920., and that death occurred, on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Intra Uterine Haemorhage

(Cause Unknown)

(Duration) ...yrs. ...mos. 4 ds.

CONTRIBUTORY (Secondary) (Excitement)

(Duration) ...yrs. ...mos. one hour ds.

(Signed) C. H. Reese M. D.

Sept 22, 1920 (Address) 3549 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Green Mount. DATE OF BURIAL, Sept 23, 1920

20-UNDERTAKER M Elwood Sons. ADDRESS 5404 W 32nd St

important. See instructions on back of certificate.

D46733

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46733

CERTIFICATE OF DEATH.

161

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 1708 N Carline St. (WARD) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie C. Gatewood

(Residence in Baltimore: No. 1708 N Carline St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. April (Month) 25 (Day), 1863 (Year)

7-AGE. 53 yrs. 4 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Housework

9-BIRTHPLACE, (State or Country). Baltimore, Md

PARENTS.

10-NAME OF FATHER. James B. Mitchell

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Emma J Sullivan

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carolyn M. Benson

(Address) 318 St Helena Ave. St Helena

15-

Filed SEP 23 1920, 191.... ROBERT P KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to *death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide Drowned from Factory Dock

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. C. Gadd M. D.
(Coroner.)

9/23/20, 191.. (Address) 1432 Gray

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetery	Sept 24, 1920
20-UNDERTAKER	ADDRESS
John B. Spence	1325 N. Carline St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

046734

HEALTH DEPARTMENT—CITY OF BALTIMORE

046734

CERTIFICATE OF DEATH.

45

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St Josephs Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Caroline Koppenhoffer

(a) RESIDENCE. NO. 1406 N. Luzerne ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, ~~DIVORCED~~ of (or) WIFE of Christian Koppenhoffer

6 DATE OF BIRTH (month, day, and year) May 16 = 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) ~~HOME~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Sophia Summer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Catherine Bauer (Address) 1406 N. Luzerne St

15 Filed SEP 23 1920 ROBERT F. LEATHERBURY Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1920 to Sept 21, 1920

that I last saw her alive on Sept 8, 1920

and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) Carcinoma bladder

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. B. Mowery, M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 24 1920

20 UNDERTAKER Henry Lutz — ADDRESS 1007 N. Bond St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D46738 HEALTH DEPARTMENT—CITY OF BALTIMORE D46735

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore

CITY OF BALTIMORE (No. General Hospital. ST.: 25 WARD) 167

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Sczepkowski.

(Residence in Baltimore: No. East Brooklyn Md.

4 --- 3 --- 18.
St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single.

6-DATE OF BIRTH, June 4th, 1916., 1
(Month) (Day) (Year)

7-AGE, 4 yrs. 3 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), East Brooklyn Md.

PARENTS.

10-NAME OF FATHER, John Sczepkowski.

11-BIRTHPLACE OF FATHER (State or Country). Poland.

12-MAIDEN NAME OF MOTHER Michalie Budni.

13-BIRTHPLACE OF MOTHER (State or Country). Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michalie Sczepkowski. (mother)

(Address) East Brooklyn Md.

15- Filed SEP 23 1920 191.... ROBERT B KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 22nd, 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns about the body.
Accidentally burned by playing with Matches. (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)
.....(Duration).....yrs.....mos.....ds.

(Signed) Otto M Rennhardt M. D.
(Coroner.)

Sept. 22rd 191 20. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.20.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?..... East Brooklyn Md.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross. A.A.Co. DATE OF BURIAL, Sept. 23, 19 20.

20-UNDERTAKER W F. Sadowski. ADDRESS 405 S. Arund

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D46736 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D46736

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 167 REGISTERED No. C.....

CITY OF BALTIMORE (No. St. Joseph's Hospital ST.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Windsor E. Evans

(Residence in Baltimore: No. 42 East ave. St.; 25 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May (Month), (Day), 1885 (Year)

7-AGE, 35 yrs. mos. da. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work Engineer 3d (b) General nature of industry, business, or establishment in which employed (or employer) Steam Boat

9-BIRTHPLACE, (State or Country), Ind.

PARENTS:

10-NAME OF FATHER, Wm. Evans

11-BIRTHPLACE OF FATHER (State or Country), Ind.

12-MAIDEN NAME OF MOTHER dont know

13-BIRTHPLACE OF MOTHER (State or Country), Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian Evans

(Address) 42 S. East ave.

15-

Filed ..... 191.....

Registrar.

SEP 23 1920

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 20 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture Skull Multiple Bruises. Accident

(Duration) ... yrs. ... mos. 2 ... da.

CONTRIBUTORY (Secondary) Shock.

(Duration) ... yrs. ... mos. 2 ... da.

(Signed) C. E. Blake M. D. (Coroner.)

9 20, 1919 (Address) 1437a Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem

DATE OF BURIAL, 9/23/, 1920

20-UNDERTAKER J. A. Moran

ADDRESS 3000 E Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 46737

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 46737

1 PLACE OF DEATH

REGISTERED No. C 120

CITY OF BALTIMORE (No. Sterile Apts 3 E ST.: 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sophia Baum

(Residence in Baltimore: No. Lakeview Park Ave St.: 60 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: April (Month) 27, (Day) 1842 (Year)

7 AGE: 78 yrs. 4 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: Eleazer Baum

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. V. Baum

(Address) Wheaton Md

15 Filed SEP 23 1920 ROBERT B. BRAUER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. (Month) 21 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1920, to Sept 20 1920
that I saw her alive on Sept 20, 1920
and that death occurred, on the date stated above, at 6 A m.
The CAUSE OF DEATH* was as follows:

Senile Nephritis

(Duration) 1 yrs. 2 mos. ds

Contributory (SECONDARY) Arterial Sclerosis

(Duration) yrs. 6 mos. ds.

(Signed) I. Strauss M. D.

Sept 21, 1920 (Address) 1920 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Pikesville Cemetery — DATE OF BURIAL: Sept 24th 1920

20 UNDERTAKER: Henry Rodheim — ADDRESS: 118 W. Mt. Royal Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Hertmanowski

D46738 HEALTH DEPARTMENT—CITY OF BALTIMORE D46738

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Belair & Lanvale St. 7 WARD) REGISTERED NO. C 64

CITY OF BALTIMORE (No.)

2-FULL NAME George Hertmanowski

(Residence in Baltimore: No. 752 Penn St (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	white	Married

6-DATE OF BIRTH. Sept 27, 1866 (Month) (Day) (Year)

7-AGE. 53 yrs. 11 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Real Estate Agent
(b) General nature of industry, business, or establishment in which employed (or employer): 686

9-BIRTHPLACE, (State or Country). Poland

PARENTS.

10-NAME OF FATHER. John Hertmanowski

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Sybilla Packniewicz

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Hertmanowski

(Address) 752 Penn St

15- SEP 23 1920 ROBERT B. LAUTER DEPUTY REGISTRAR

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 22, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigator (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Edward Sidney Gudley M. D. (Coroner)

Sept 22 1920 (Address) 1800 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Sept 25, 1920
20-UNDERTAKER	ADDRESS
John A. Weber	1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46739 D46739

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 8 N. Chapel ST.; 6 WARD)

2-FULL NAME Anastazya Zezulewska

(a) RESIDENCE. NO. 8. N. Chapel. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wht'e

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single.

6 DATE OF BIRTH (month, day, and year): Mar. 1—20

7 AGE — Years: — Months: 6 — Days: 20 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 6.20

(b) General nature of industry, business, or establishment in which employed (or employer): " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Zezulewska

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Frances Zuchowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: John Zezulewska
(Address): 8 N. Chapel

15 Filed SEP 23 1920 Registrar

ROBERT P. BRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 19 20, to Sept 23, 19 20, that I last saw her alive on Sept 20, 19 20, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

acute dysentery

(duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary): over

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Wachter M. D.

Sept 23 1920 (Address) 62 N. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Sept. 24 1920

20 UNDERTAKER: M. F. Trautwein — ADDRESS: 1618 Eastern ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of the disease is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46740

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46740

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618. Eastern Ave. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Falkowski

(a) RESIDENCE. NO. 1618 Eastern Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of — — —

6 DATE OF BIRTH (month, day, and year) May 20-20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER William Falkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Zamarowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant William Falkowski
(Address) 1618 Eastern Ave

15 Filed ..., 19 ...
SEP 23 1920 ROBERT B ... Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 19 20, to Sept 23, 19 20, that I last saw h... alive on Sept 20, 19 20, and that death occurred, on the date stated above, at 7:40 p. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) J. Wentzen, M. D.

1920 (Address) 42 N Bentley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Sept 24 1920

20 UNDERTAKER ... ADDRESS ...

Wm Falkowski 1618 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of the CONDITION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46741 ✓ 104 D46741

CERTIFICATE OF DEATH.

D46741

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1738 Johnson ST.; 24 WARD)

2-FULL NAME Vernon L. Rishbeck

(a) RESIDENCE. NO. 1738 Johnson ST., 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4 1920

7 AGE — Years | Months 8 | Days 8 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Rishbeck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Agnes Kirby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant John Rishbeck (Address) 1738 Johnson St

15 Filed SEP 23 1920 19... ROBERT E. LEAVELL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1920, to Sept 22, 1920, that I last saw h[illegible] alive on Sept 22, 1920, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Dr. H. C. Hampton M. D.

Sept 23 1920 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem — DATE OF BURIAL: 9/24 1920

20 UNDERTAKER: I. Frew McCully — ADDRESS: 130 E Fay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D46742 HEALTH DEPARTMENT—CITY OF BALTIMORE D46742

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Maryland Genl Hosp, ST.: 18 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry C. Holmes

(Residence in Baltimore: No. 525 N. Franklin St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, January 15, 1880.
(Month) (Day) (Year)

7-AGE, 40 yrs. 9 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Henry W. Holmes,

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Catherine Augheier,

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marty Augheier

(Address) 120 Saw Bldg.

15- SEP 23 ROBERT B. BRAUTER

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 21, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

..... (Duration).....yrs.....mos...1...ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration).....yrs.....mos.....ds.

(Signed) C. J. Heuisler M. D.
(Coroner.)

Sept 23, 1920. (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death Md. Gen. Hosp. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

525 N. Franklin St.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Sept 24, 1920
20-UNDERTAKER	ADDRESS
Geo. J. Smith	1000 N. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46743

CERTIFICATE OF DEATH.

151 D46743

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 S Sharp ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John David Mooney

(a) RESIDENCE. No. 406 S Sharp ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 23 1920

7 AGE Years Months Days If LESS than 1 day, 2 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edw Mooney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Christina Carey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Edw Mooney
(Address) 406 S Sharp st

15 Filed ..... 19 .....
Registrar

SEP 23 1920
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1920, to Sept 23, 1920, that I last saw h~~im~~ alive on Sept 23, 1920, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Both

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clarence Schumacher M. D.

Sept 23. 1920 (Address) 1414 Lois St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 9/23/20

20 UNDERTAKER: Geo A Farley Fulton — ADDRESS: Fayette

IMPORTANT: Before filling out this certificate, read carefully the instructions on the back of the certificate. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.46744

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46744

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD) 79

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Wachter

(a) RESIDENCE. NO. Lime Kiln Md. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): (Widowed)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: 0

6 DATE OF BIRTH (month, day, and year): Sept 1866

7 AGE: About Years 54 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Roy Wachter

(Address) Lime Kiln Frederick Co Md

15 Filed SEP 23 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1920, to Sept 23, 1920, that I last saw h[er] alive on Sept 23, 1920, and that death occurred, on the date stated above, at 6 15a m.

The CAUSE OF DEATH* was as follows:

Intercranial Insufficiency

Bronchial Asthma

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Edema Lungs

(duration) yrs. mos. 2 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. G. Guyer, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery Frederick Md

DATE OF BURIAL: 9/25 1920

20 UNDERTAKER: C C Canby

ADDRESS: Frederick Md.

IMPORTANT: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46745

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46745

108

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert R. Seidewitz

(a) RESIDENCE. NO. Belvedere Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. 0 mos. 19 ds. How long in U. S., if of foreign birth? 24 yrs. 0 mos. 19 ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 3, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	0	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edwin Seidewitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Adele Wattenheid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Adele Seidewitz.
(Address) Belvedere Ave & Old Pimlico Rd

15 Filed SEP 23 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1920, to Sept. 22, 1920,
that I last saw him alive on Sept 22, 1920,
and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Suppurative Appendicitis,
with partial obstruction,
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Mesenteric Thrombosis
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept. 17, '20
Sept. 20, '20.

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) Thos Flinn, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	9/24 19 20
20 UNDERTAKER	ADDRESS
Henry W. Kears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.46746 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.46746

CERTIFICATE OF DEATH. X40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Harry Demaras

(a) RESIDENCE. No. 12 S. Potomac St. WARD. Hagerstown Md

(Usual place of abode) (If nonresident give city or town and state)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	M.

If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Demaras

6 DATE OF BIRTH (month, day, and year) [illegible] ? 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Storekeeper 24th

(b) General nature of Industry, business, or establishment in which employed (or employer) Saloon-keeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " " "

12 MAIDEN NAME OF MOTHER " " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " " "

14 Informant Mr. James Demaras (Address) Hagerstown Md

15 Filed SEP 23 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-21 1920

17 I HEREBY CERTIFY, That I attended deceased from 8-17, 1920, to 9-21, 1920 that I last saw h[illegible] alive on 9-21, 1920 and that death occurred, on the date stated above, at 4:00 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver & pancreas.

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8-22-20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Ellis Craig, M. D.

. 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Sep 23 1920
20 UNDERTAKER Martin Fahey & Sons	ADDRESS 827 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates. OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46747 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46747

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Dixon Park, Mt Washington REGISTERED NO. 79

CITY OF BALTIMORE: (NO. ..... ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Kate Lyons

(a) RESIDENCE. NO. 1924 Park ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Lyons, deceased

6 DATE OF BIRTH (month, day, and year) Aug. 15, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Castlereagh, Ireland

PARENTS

10 NAME OF FATHER John Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Abrahams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant William P. Lyons
(Address) 2000 Bolton St., Balto., Md.

15 Filed SEP 23 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1920

17 I HEREBY CERTIFY, That I attended deceased from —, 1917, to Sept 21, 1920, that I last saw h[illegible] alive on Sept 21, 1920, and that death occurred, on the date stated above, at 10 P.M. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Enlarged Heart

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Amerine E. Ford, M. D.

Sept 22, 1920 (Address) Mt Washington.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Cemetery	Sept 22 1920
20 UNDERTAKER	ADDRESS
E. A. Wedefeld Jr	Franklin Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.46748

1 PLACE OF DEATH

County Baltimore 410 E. 25th. or. 40

Village or City Baltimore (No. 410 E. 25th. St. St.; 17 Ward)

D.46748

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. .....

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Martin Luther Jarrett 3 yrs

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: November 18, 1841 (Month) (Day) (Year)

7 AGE: 79 yrs. 10 mos. 5 ds. If LESS than 1 day, ... hrs. OR ... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Physician 054
(b) General nature of industry business, or establishment in which employed (or employer): Retired 17 years

9 BIRTHPLACE (State or country): Harford Co Md

PARENTS

10 NAME OF FATHER: Luther M Jarrett

11 BIRTHPLACE OF FATHER (State or country): Harford Co Md

12 MAIDEN NAME OF MOTHER: Julia A Scarff

13 BIRTHPLACE OF MOTHER (State or country): Harford Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Merryman Dead

(Address) 410 25th St Baltimore Md

15 Filed SEP 23 1920, 191 Robert P. Harrison, Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: September (Month) 23 (Day) 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from August 1st, 1920, to Sept 23rd, 1920, that I last saw h[illegible] alive on Sept 21st, 1920, and that death occurred on the date stated above, at 12.10 pm.

The CAUSE OF DEATH * was as follows:

Carcinoma of liver + intestines No operation

Six Years (Duration) yrs. mos. ds.

Contributory (Secondary) Pneumonia Grippe

6 hrs (Duration) yrs. mos. ds.

(Signed) Geo H Bairne M D

Sept 23rd, 1920 (Address) 2121 Linden Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 3 yrs. mos. ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Jarrettsville Md — DATE OF BURIAL: Sept. 25, 1920

20 UNDERTAKER: E H Kurtz & Son — ADDRESS: Jarrettsville Md

* If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. ....

2 B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0946749 HEALTH DEPARTMENT—CITY OF BALTIMORE 0946749

CERTIFICATE OF DEATH. 104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 Burgundy ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Bury

(a) RESIDENCE. NO. 1106 Burgundy ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 29 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) nil

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) md.

PARENTS

10 NAME OF FATHER Laurence Bury

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Katie Peterbach

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs Katie Peterbach
(Address) 1106 Burgundy st

15 SEP 24 1920 ROBERT J. BRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1920, to Sept 23, 1920, that I last saw her alive on Sept 23, 1920, and that death occurred, on the date stated above, at 8.45 A m.

The CAUSE OF DEATH* was as follows:

Gastritis acute

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Inflammation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Crumpton, M. D.

9/24 1920 (Address) 317 Lenox

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet cemetery	Sept 24 1920
20 UNDERTAKER James Dignan & Son.	ADDRESS 101 S. Paca St

REGISTRAR SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D46750 D46750 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 414 Rosedale St. 20 WARD)

2-FULL NAME Charles H Weaver

(a) RESIDENCE. NO. 414 Rosedale St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Weaver

6 DATE OF BIRTH (month, day, and year) Apr. 25, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Anna Gruin 414 Rosedale

15 Filed SEP 24 1920 ROBERT B. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1920.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to Sept 22, 1920.

that I last saw H[illegible] alive on Sept 22 1920

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Art. Sclerosis

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) W. A. Knell, M. D.

9/22, 1920 (Address) 420 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Hebron Cem Winchester Va

DATE OF BURIAL Sept 25 1920

20 UNDERTAKER John J Cowan & Son

ADDRESS 901 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46751

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46751

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 Ryan St — ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia C. Doody

(a) RESIDENCE. No. 921 Ryan St — ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 11 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 28th 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11.	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Lawrence Doody

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary C Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mr Lawrence Doody
(Address) 921 Ryan St

15 Filed SEP 24 1920 ROBERT T. HAUTH Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1920 to Sept 22, 1920.

that I last saw h[illegible] alive on Sept 20, 1920.

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Uremia Coluria

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Lawrence M. D.

, 19 (Address) 1170 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	Sept 24th 1920
20 UNDERTAKER	ADDRESS
John Heavan & Son	921 Ryan St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Lidia Trubka.

D46752 HEALTH DEPARTMENT—CITY OF BALTIMORE D46752

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 645 W Pratt ST. 27 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lidia Trubka

(Residence in Baltimore: No. 645 W Pratt St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, ... May (Month) 20 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
.....yrs. 2 mos. .....ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balt city

PARENTS.

10-NAME OF FATHER, Joseph Trubka

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Antkow

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lida Trubka

(Address) 645 W Pratt

15- SEP 24 1920 ROBERT E KRAUTER

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Endocarditis Streptococcal .....

..... (Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) ..... Unknown Cause .....

..... (Duration) ....yrs. ....mos. 7 ds.

(Signed) ..... M. D. (Coroner.)

9-24, 1920 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Thomas Cath	Sept 24, 1920
20-UNDERTAKER	ADDRESS
Geo Lindsay & Co	Govans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D46753

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46753

CERTIFICATE OF DEATH.

91

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1020 Parrish alley ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lady Woodson

(Residence in Baltimore: No. 1020 Parrish alley St.; yrs., 8 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	single

6-DATE OF BIRTH, Feb. (Month) 20 (Day), 1920 (Year)

7-AGE, ...yrs. 8 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, William Woodson

11-BIRTHPLACE OF FATHER (State or Country), Kentucky

12-MAIDEN NAME OF MOTHER Daisy Hodges

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Drusilla Hodges

(Address) 130 Chilg St.

SEP 24 1920

Filed....., 191.... ROBERT F. LEUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Hennessy M. D. (Coroner.)

Sept 22, 1920 (Address) 2202 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters — DATE OF BURIAL, Sept. 24, 1920

20-UNDERTAKER JAMES H. DENNIS — ADDRESS 1303 PRESTMAN ST.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.--6-9-19--H. P. Co.--1000 Blks.

D46754 HEALTH DEPARTMENT—CITY OF BALTIMORE D46754

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Jenifer

(a) RESIDENCE No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 10

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

Date Received SEP 24 1920 ROBERT F KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1920, to Sept. 22, 1920, that I last saw her alive on September 21, 1920, and that death occurred, on the date stated above, at 3:05 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.
Cerebral Hemorrhage

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. diffuse nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test.

(Signed) W Bletzman M. D.

9/22/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	SEP 24 1920
20 UNDERTAKER JAMES H. DENNIS	ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1934 5-1 6755

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 10467 5-5

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.: — WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Cohen

(a) RESIDENCE. No. 1517 N. High St. Baltimore Md WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Hyman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Fannie Kapz.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant J. H. H. Records
(Address)

15 Filed SEP 24 1920 19 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept. 9 1920, to Sept 22 1920, that I last saw h[illegible] alive on Sept 22 1920, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea
Not dysentery

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bath Rehrens Cem	9/24 1920
20 UNDERTAKER Jack Levin	ADDRESS 411 Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D46786 HEALTH DEPARTMENT—CITY OF BALTIMORE D46756

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 605 George St.: 17 WARD)

REGISTERED No. C 19

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Garner

(Residence in Baltimore: No. 605 George St. St.: 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, Unknown (Month) (Day), 1856 (Year)

7-AGE 64 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Driver (Beer wagon)
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland (Carroll Co.)

PARENTS.

10-NAME OF FATHER, Dennis Garner

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Garner

(Address) 605 George St

15-

Filed SEP 24 1920 ROBERT B. KLAUTER

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 21 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Organic Heart Disease

(Duration) yrs. 7 mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Sept 21, 1920 (Address) 202 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cem.	Sept 23 1920
20-UNDERTAKER Samuel Hensley	ADDRESS 578 N Bridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Maida Stabe

D46757 HEALTH DEPARTMENT—CITY OF BALTIMORE D46757

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 92

CITY OF BALTIMORE (No. Johns Hopkins Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maida Stabe

(Residence in Baltimore: No. 1100 Russell St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Married

6-DATE OF BIRTH, May (Month) 12 (Day) 1901 (Year)

7-AGE, 19 yrs. mos. ds. — If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Samuel R Boyd

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Mary Herbich

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samil R Boyd

(Address) Arlington

15- SEP 24 1920 ROBERT P. LATIMER

Filed ....., 191.... REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 22 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner.)

9/22/20 (Address) 1453 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. — DATE OF BURIAL, Sept 24, 1920

20-UNDERTAKER Chas. E. Brandt — ADDRESS 807 Madison Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BURIAL PERMIT (Reverse)

Spec.—6-9-19—H. P. Co.—1000 Bks.

146758 HEALTH DEPARTMENT—CITY OF BALTIMORE 146758

CERTIFICATE OF DEATH.

105

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S. 14 St.; 26 WARD)

2-FULL NAME G. Leonard Loewer

(a) RESIDENCE. No. 319 S. 14 St., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred abt. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Loewer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Annie M. Foley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant George Loewer
(Address) 319 S. 14th St

15 Filed SEP 24 1920, 19 ROBERT J. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23rd 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 21st, 1920, to Sept 23rd, 1920, that I last saw him alive on Sept 23rd, 1920, and that death occurred, on the date stated above, at 3:10 A m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) ~

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? ~

(Signed) Adam Jost, M. D.

19 (Address) 4704 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept 24 20
20 UNDERTAKER	ADDRESS
Jos. J. Lee	151 S. Eutaw St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should be careful to see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

2046759 HEALTH DEPARTMENT—CITY OF BALTIMORE 2046759

CERTIFICATE OF DEATH.

37

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Heath

(a) RESIDENCE. NO. Johns Hopkins Hospital ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) 9-22-20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Dalto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Edwin Heath

11 BIRTHPLACE OF FATHER (city or town) "
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Jennie Watson

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country) Virginia

14 Informant Dr. E. L. Stone
(Address) Johns Hopkins Hospital.

15 Filed SEP 24 1920 ROBERT E. LAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22 1920

17 I HEREBY CERTIFY, That I attended deceased from 9-22, 1920, to 9-22, 1920, that I last saw h. alive on 9-22, 1920, and that death occurred, on the date stated above, at 9.01 p.m.

The CAUSE OF DEATH* was as follows:

Prematurity - Syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 9-22-20

Was there an autopsy? → Low Forceps Delivery

What test confirmed diagnosis?

(Signed) Emerson L. Stone, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL SEP 24 1920, 19

20 UNDERTAKER Commissioner of Health, per. WM. E. WOODALL — ADDRESS

mation should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1046760

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046760

CERTIFICATE OF DEATH.

104

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 831 Power ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy E. Allen

(Residence in Baltimore: No. 831 Power St St.; 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Aug. (Month) 6 (Day), 1919 (Year)

7-AGE,	If LESS than 1 day,
yrs. 1 mos. 17 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. John T. Allen

11-BIRTHPLACE OF FATHER (State or Country). Balto. Co

12-MAIDEN NAME OF MOTHER Ruth M. Miller

13-BIRTHPLACE OF MOTHER (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John T. Allen

(Address) 831 Power St.

15- SEP 24 1920 Filed....., 191.... ROBERT B. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. September 23 (Month) (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 21 1920, to Sept. 23 1920, that I saw her alive on Sept. 23 1920, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Toxaemia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Toxaemia

(Duration) yrs. mos. ds.

(Signed) Unattended M. D.

Sept 24, 1920. (Address) 3429 Chesterfield Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loraine Cemetery	Sept 25, 191

20-UNDERTAKER	ADDRESS
A. S. Marshall	3539 Fell Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Cernohorsky

HEALTH DEPARTMENT—CITY OF BALTIMORE

2046761 2046761

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 N Lakewood Av ST.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or Institution, give Its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Emilia Cernohorsky

(Residence in Baltimore: No. 725 N. Lakewood Av St.; ..... yrs., ... mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Fem'l	White	Single

6-DATE OF BIRTH, Sept (Month) 17 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
....yrs. ....mos. 6 da.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Anthony Cernohorsky

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Emilia Schebb

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anthony Cernohorsky

(Address) 725 N Lakewood Av

15-

Filed SEP 24 1920 191..... ROBERT F. LEUTER

Burial Permit Register

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/17/20 191..., to 9/23/20 191..., that I saw her alive on 9/23/20 191..., and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

..... Marasmus .....

..... (Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Seymour M. D.

9/24/20, 191... (Address) 952 E Hummert St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Sept 24 1920
20-UNDERTAKER	ADDRESS
Smith Gracheson	1906 Gorsuch Av

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate. ACCURATE should be taken EXACTLY. PHYSICIANS should state may be properly classified. Exact statement of OCCUPATION is very

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 46762

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46762

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 17 WARD)

2-FULL NAME Leon Watkins

(a) RESIDENCE. NO. 824 Little George st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jennie Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M.T.H.

Filed SEP 24 1920 ROBERT I ILLUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 23, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1920, to Sept. 23, 1920, that I last saw him alive on Sept. 22, 1920, and that death occurred, on the date stated above, at 8.35 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed) L. J. Rigney, M. D.

9-23-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 24 1920
20 UNDERTAKER	ADDRESS
Daniel Easter	Bo and

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are required by law to report this case to the Health Department immediately after death. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D46763 HEALTH DEPARTMENT—CITY OF BALTIMORE D46763

CERTIFICATE OF DEATH.

REGISTERED No. C 1667

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 920 N. Calhoun St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hezekiah C. Shipley

(Residence in Baltimore: No. 920 N. Calhoun St.; St.: 37 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	married

6-DATE OF BIRTH, September 3, 1883
(Month) (Day) (Year)

7-AGE, 37 yrs. 1 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer (General)
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Charles Coaly

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Estella Shipley

(Address) 920 N. Calhoun St.

15- SEP 24 1920 ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Kennedy M. D.
(Coroner.)

Sept 22, 1920 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Star Cem.	Sept. 24 1920
20-UNDERTAKER Daniel Easton	ADDRESS 916 Pe ne

AGE should be stated EXACTLY. PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be proper... information should be carefully supplied.

—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

764 — 37 — 2046764

REGISTERED NO.

PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

F BALTIMORE: (No.) New City Hospital ST.: 4 WARD)

ULL NAME James Murphy

RESIDENCE. No. 141 N. Gay St. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)
of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

arried, widowed, or divorced
USBAND of
) WIFE of

E OF BIRTH (month, day, and year) 1870

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Camp Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: J.F. Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Sarah Kelley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Massachusetts

14 Informant: Hospital Records.
(Address): New City Hospital.

15 Filed SEP 24 1920 ROBERT J. SLUTER Registrar
Burial Permit Clerk

N. B.—WRI... mation should be ca... CAUSE OF DEATH in p... TION is very important. See ins...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 20 1920

17

I HEREBY CERTIFY, That I attended deceased from August 31, 1920, to September 20, 1920, that I last saw h. im alive on September 20, 1920, and that death occurred, on the date stated above, at 8:30 P.m.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) 14 yrs. mos. ds.

CONTRIBUTORY (Secondary): Aneurism of abdominal aorta. (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Indo-China.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Wassermann.

(Signed) [illegible] M. D.

9/21/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF [redacted] CREMATION [redacted]: Bay View Hospital

DATE OF BURIAL: 9-23-1920

20 UNDERTAKER: J. B. Stunter

ADDRESS: B.V.H.

...—H. P. Co.—1000 Bks.

6765
6765
PLACE OF DEATH

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 46765

REGISTERED NO.

BALTIMORE: (No. Balto 3117 Homestead Montebello ave. WARD 9)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME John Dwerbeck

RESIDENCE. No. nursery Childs Hosp ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

...le	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
	white	single

...arried, widowed, or divorced
...USBAND of
...or) WIFE of

...ATE OF BIRTH (month, day, and year) Sept 30 1919

...AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

BIRTHPLACE (city or town) (State or country) Balto md

10 NAME OF FATHER John C Dwerbeck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Amelia Welch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Mrs Wallace Dwerbeck
(Address) 3117 Montebello Ave

Filed SEP 24 1920 ROBERT B ...LAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 14, 1920, to Sept 23, 1920, that I last saw h... alive on Sept 23, 1920, and that death occurred, on the date stated above, at 1200 N. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) ? yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) J. O. Ridgely M. D.

. 19 (Address) Nursery Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept 24 1920
20 UNDERTAKER	ADDRESS
E A Ridgely Jr	501 E 22nd St

—H. P. Co.—1000 Bks.

766

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046766

CERTIFICATE OF DEATH.

172

ACE OF DEATH

REGISTERED NO.

BALTIMORE: (No. 1100 S. East ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

LL NAME Solomon A. Bunier

RESIDENCE. No. 1100 S. East ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

f residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
le	White	Widower

rried, widowed, or divorced USBAND of r) WIFE of -

E OF BIRTH (month, day, and year) Nov. 14-1843

Years	Months	Days	If LESS than 1 day, hrs. or min.
76	10	10	

CUPATION OF DECEASED

) Trade, profession or rticular kind of work Watchman Retired 14 yrs.

) General nature of industry, siness, or establishment in hich employed (or employer)

) Name of employer Penna R.R.

IRTHPLACE (city or town) Frederick Co.
(State or country) Md.

10 NAME OF FATHER Solomon Buried

11 BIRTHPLACE OF FATHER (city or town) Frederick Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Link

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

Informant Luella H. Nichols
(Address) 1100 S. East ave.

5 SEP 24 1920 ROBERT F. LAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7th, 1920, to Sept 24th, 1920, that I last saw him alive on Sept 23rd, 1920, and that death occurred, on the date stated above, at 3.20 A. m.

The CAUSE OF DEATH* was as follows:

over

Acute Nephritis

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Probable fracture of left femur (duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis

(Signed) W. W. Jones M. D.

19 (Address) 1013 N. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cemetery Hampden	Sept. 26 1920
20 UNDERTAKER	ADDRESS
Zirkler + Zirkler	1709 E. Eager St.

H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

105 2046767

767

CERTIFICATE OF DEATH.

REGISTERED NO.

CE OF DEATH

ALTIMORE: (No. 1010 Warden ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

L NAME George H. Dotterweich

ESIDENCE. NO. 1010 Warden ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

ERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
ale	White	Single

ried, widowed, or divorced
SBAND of
WIFE of

OF BIRTH (month, day, and year) Aug 10, 1912

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
8	1	13	

UPATION OF DECEASED

Trade, profession or icular kind of work

General nature of industry, iness, or establishment in ich employed (or employer)

Name of employer

THPLACE (city or town) Baltimore
tate or country)

0 NAME OF FATHER Henry J. Dotterweich

1 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER May Walter

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

Informant Henry J. Dotterweich
(Address) 1010 Warden st

Filed SEP 24 1920 ROBERT F. LEIDER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 27th, 1920, to Sept 23, 1920,

that I last saw him alive on Sept 20th, 1920,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Gastro Entero Catarrh

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) S. S. Horan, M. D.

Sept 24th 1920 (Address) 1501 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	Sept 25 1920
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

768 ✓ 2046768

CERTIFICATE OF DEATH.

+137

ACE OF DEATH — REGISTERED NO.

BALTIMORE: (No. St Josephs Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ULL NAME Clyde Spencer

RESIDENCE. NO. Fallston Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

arried, widowed, or divorced USBAND of er) WIFE of Nov. 28 1897

E OF BIRTH (month, day, and year)

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
22	9	27	

CUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hard work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Grayson Co Va

10 NAME OF FATHER Millard Testerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Grayson Co Va

12 MAIDEN NAME OF MOTHER Amond Greer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Grayson Co Va

14 Informant (Address) Franklin E. Spencer Fallston Md

15 [illegible] SEP 24 1920 ROBERT I ELLIOTT [illegible]

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 3 — 1920, to Sept 24, 1920

that I last saw h[illegible] alive on Sept 24, 1920

and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicaemia

(duration) — yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 10 ds.

18 Where was disease contracted If not at place of death? not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H B McElwain, M. D.

, 19 (Address) St Josephs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fallston Md.	9/24/ 1920
20 UNDERTAKER	ADDRESS
Wm Tickner & Sons	Pennsylvania Ave

—H. P. Co.—1000 Bks.

6769

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 46764

CERTIFICATE OF DEATH.

× 172

PLACE OF DEATH

BALTIMORE: (NO. University Hospital ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Walter Robinson

RESIDENCE. NO. Fredericksburg Md ST., WARD. Fredericksburg Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

(If married, widowed, or divorced) WIFE of (or) HUSBAND of

DATE OF BIRTH (month, day, and year) June 14, 1911

Years	Months	Days	If LESS than 1 day, hrs. or min.
9 nine	3	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Fredericksburg. Md

10 NAME OF FATHER Elmer Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nellie Lyden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant University Hospital Records (Address)

15 Filed 24 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1920, to Sept 23, 1920, that I last saw h[illegible] alive on Sept 23, 1920, and that death occurred, on the date stated above, at 11.55 P.m.

The CAUSE OF DEATH* was as follows:

Surgical shock due

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 22, 1920.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Myers F. Norris, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Denton Md — DATE OF BURIAL: Sept 26 1920

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 531 W Lanvale

—H. P. Co.—1000 Blks.

6770 HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46770

28-091

CERTIFICATE OF DEATH.

REGISTERED NO.....

PLACE OF DEATH

BALTIMORE: (No. New City Hospital. ST.. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Rosie Siebert

RESIDENCE. No. 1403 Pennsylvania Ave ST., ... WARD.
(Usual place of abode)

of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Married

Married, widowed, or divorced (HUSBAND of (or) WIFE of) Unknown

DATE OF BIRTH (month, day, and year) 1900

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
20			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

BIRTHPLACE (city or town) (State or country) South Carolina

10 NAME OF FATHER James Streetor

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Nancy Barrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records

(Address) New City Hospital.

15 Filed 9/24 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1920, to Sept. 22, 1920.

that I last saw her alive on September 21, 1920.

and that death occurred, on the date stated above, at 6:40 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? no of course test

(Signed) F. C. Holden M. D.

9/22/1920 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Sept 24 1920
20 UNDERTAKER	ADDRESS
Edw. Ringgold	1463 N. Gay St

24-14—M. & T.—2000 Bks.

2771 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46771

CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. 734 Asquith ST.; 10 WARD) REGISTERED NO. C 79

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Margaret A. Farmer

ence in Baltimore: No. 734 Asquith St (St.; 60 yrs. mos. ds.)

ERSONAL AND STATISTICAL PARTICULARS.

	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	White	Single

TE OF BIRTH, Sept. 23, 1850 (Month) (Day) (Year)

E, 70 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

CCUPATION:
) Trade, profession, or particular kind of work: Housekeeper
) General nature of industry, business, or establishment in which employed (or employer): None

IRTHPLACE, State or Country), Ireland

10-NAME OF FATHER, Terence Farmer

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Ann Quinn

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Farmer

(Address) 734 Asquith St

15- SEP 24 1920 Robert P. Harrison, Registrar. 191 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH. 1721

16-DATE OF DEATH, September 22, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1920, to Sept 22 1920, that I saw h[illegible] alive on Sept 21 1920, and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Chr endocarditis

Myocarditis

possible embolism

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. J. Kinlow M. D.

Sept 23, 1920 (Address) 1100 E. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Marys. Com. Govanstown	Sept 25, 1920

20-UNDERTAKER	ADDRESS
Frank A. Fink	915 N. Gay St

19—H. P. Co.—1000 Bks.

2772 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.46772

CERTIFICATE OF DEATH. 28

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. 30 S. Fulton Ave ST.) 19 (WARD)

FULL NAME Etta Larrimore

RESIDENCE. No. 30 S. Fulton Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Don't Know

DATE OF BIRTH (month, day, and year) July 22 - 1888

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	3		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robert L. Harrington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Emma Whaley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Emma Harrington (Address) 30 S. Fulton Ave.

15 Filed SEP 24 1920 16 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23, 1920

17

I HEREBY CERTIFY, That I attended deceased from August 1, 1920, to Sept 23, 1920, that I last saw her alive on Sept 23, 1920, and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) M. O'Neill, M. D.

9/23, 1920 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Sept 27 - 1920

20 UNDERTAKER William Cook

ADDRESS 503 E. North Ave

9—H. P. Co.—1000 Bks.

6773 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.46773

81

CERTIFICATE OF DEATH.

REGISTERED NO.

PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (No. New City Hospital. ST.: 3 WARD)

FULL NAME John Wise

RESIDENCE. NO. 1421 Boundy Lane ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Unknown

If married, widowed, or divorced
WIFE of (or) HUSBAND of Unknown

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Unknown	60			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Unknown

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

PARENTS

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed SEP 24 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21, 1920

17 I HEREBY CERTIFY, That I attended deceased from September 16 1920, to September 21 1920.

that I last saw him alive on September 20. 1920.

and that death occurred, on the date stated above, at 4:00 A. m.

The CAUSE OF DEATH* was as follows:

Arterio - sclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile deterioration.

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test.

(Signed) V. Bettman, M. D.

9/21/1920 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL SEP 24 1920

20 UNDERTAKER Commissioner Health

ADDRESS

4-14—M. & T.—2000 Bks.

774 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46774

CERTIFICATE OF DEATH. X 109

REGISTERED NO. C.....

PLACE OF DEATH

OF BALTIMORE: (No. Maryland Penitentiary ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Joel James

...nce in Baltimore: No. ..... St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Black	Single

E OF BIRTH.

....., 1896
(Month) (Day) (Year)

...24... yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

OCCUPATION:
(a) Trade, profession, or particular kind of work ..... General Jt°
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Laborer

BIRTHPLACE, (State or Country) Lawrenceville, Va.

10-NAME OF FATHER. Emmett Walker

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Patrick J. Brady

(Address) Md. Penitentiary

15-

Filed ....., 191...

Registrar.

SEP 24 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: September 18, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 9 1920, to September 18 1920, that I saw him alive on September 17 1920, and that death occurred, on the date stated above, at 5:10 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

Toxemia

..... (Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Intestinal Obstruction

..... (Duration) ....yrs. ....mos. 9 ds.

(Signed) William J. Edwards M. D.

....., 191... (Address) Md. Penitentiary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 9 mos. 23 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. SEP 2, 1920 ....., 191...

20-UNDERTAKER Robert P. Harrison, Commissioner of Health, ADDRESS

per. Wm. H. Woods.

UNIVERSITY OF MARYLAND

H. P. Co.—1000 Bks.

775 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46775

81

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

BALTIMORE: (No. Raspe n Delaware Ave ST.; 16 WARD)

FULL NAME Georg D. Herold

RESIDENCE. NO. Raspe n Delaware Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
If residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6 If married, widowed, or divorced (HUSBAND of (or) WIFE of) Mary Herold

7 DATE OF BIRTH (month, day, and year) Aug. 31-1843

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	—	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocer
(b) General nature of industry, business, or establishment in which employed (or employer) Retired 7 years
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) M.d.

10 NAME OF FATHER Peter J. Herold

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) M.d.

12 MAIDEN NAME OF MOTHER Elizabeth Darr

13 BIRTHPLACE OF MOTHER (city or town) M.d
(State or country)

14 Informant Mary Herold
(Address) Raspe n Delaware Ave

15 Filed SEP 24 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1920

17 I HEREBY CERTIFY, That I attended deceased from September-15, 1920, to September-22, 1920, that I last saw him alive on September-22, 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Toxemia - Exhaustion - Diarrhoea
arteriosclerosis - Prostatitis - Chronic
Cystitis
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Senility (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis-

(Signed) William F. Schwartz, M. D.

9/24, 1920 (Address) 1200 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. DATE OF BURIAL Sept 25 1920

20 UNDERTAKER H. Sander Sons ADDRESS 1710 East St

Dr Schwartz, 1200 N Caroline

—B. P. Co.—1000 Bks.

776 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46776

CERTIFICATE OF DEATH.

79 REGISTERED NO.

PLACE OF DEATH

BALTIMORE: NO. 1724 N Bethel ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Minnie Fabig

RESIDENCE. NO. 1724 N Bethel ST., 8 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? 45 yrs. mos. ds.

of residence in city or town where death occurred 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: Female White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

married, widowed, or divorced WIFE of Friedrich Fabig dece...

DATE OF BIRTH (month, day, and year) Dec 1 1855

64 Years 9 Months 22 Days

If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Krieger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Minnie Fabig (Address) 1724 N Bethel St

15 Filed SEP 24 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1920

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1920, to Sept 23, 1920.

that I last saw h alive on Sept 23, 1920.

and that death occurred, on the date stated above, at 2:15 p m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 4 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob Fisher M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Evergreen St Pauls Cem

DATE OF BURIAL: Sept 26 1920

20 UNDERTAKER: Louis Hoermann

ADDRESS: 32 N Broadway.

4-14—M. & T.—2000 Bks.

6777 D.46777

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

PLACE OF DEATH

OF BALTIMORE. (No. 533 Byrd ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME John Kumpf.

ence in Baltimore: No. 533 Byrd & L St.; 6 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
m	White	Widower

E OF BIRTH, 1 (Month) 16 (Day), 1836 (Year)

E, 84 yrs. 8 mos. 6 ds. | If LESS than 1 day, ...hrs. or....min.?

CUPATION:
) Trade, profession, or particular kind of work: Carpenter
) General nature of industry, business, or establishment in which employed (or employer): Ret'd

IRTHPLACE, State or Country), Germany

10-NAME OF FATHER, Adam Kumpf

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Lebpert

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Sophie Kumpf

(Address) 533 Byrd & L St.

15-

Sep 24 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jany 1920, to 9.22 1920, that I saw h im alive on 9.22 1920, and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

One week (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old Age Infinitis

One year (Duration) yrs. mos. ds.

(Signed) D.J. Purlington M. D.

9.23, 1920 (Address) 1.87 E Fort Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Westen Cemetery	Sep. 25, 1920

20-UNDERTAKER	ADDRESS
E. J Fanning & Son	1938 E Lafayette

N. P. Co.—1000 Blks.

778 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46778

CERTIFICATE OF DEATH. X 145

ACE OF DEATH -

BALTIMORE: (No. University Hospital ST.; WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

LL NAME John M Street

RESIDENCE. NO. Cumberland Md ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
n	White	Married

arried, widowed, or divorced USBAND of r) WIFE of

E OF BIRTH (month, day, and year) Dec 24-1859

Years	Months	Days	If LESS than 1 day, hrs. or min.
60	7		

CUPATION OF DECEASED

a) Trade, profession or particular kind of work Manager

b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER John J Street

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Katherine Walters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John J. Street.

(Address) Cumberland Md

SEP 24 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/24 1920

17

I HEREBY CERTIFY, That I attended deceased from 9/17/20 1920, to 9/24, 1920

that I last saw him alive on 9/24/20, 1920

and that death occurred, on the date stated above, at 6 30A m.

The CAUSE OF DEATH* was as follows:

Pneumonia Folliacea

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insuff.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Cumberland Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goedsborough M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cumberland Md.	Sept. 24 1920
20 UNDERTAKER	ADDRESS
Henry W Hutkins & Sons Co	McCulloh & Orchard Sts

24-14—M. & T.—2000 Bks.

6779 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46779

CERTIFICATE OF DEATH. 151

REGISTERED NO. C.....

PLACE OF DEATH

OF BALTIMORE: (No. Center Bay ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME (Infant) Hammer

ence in Baltimore: No. 1420 Grace Court St.: ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
male	white	Sgle

E OF BIRTH, Sept. 24, 1920
(Month) (Day) (Year)

E, ...yrs. —mos. —da. | If LESS than 1 day, 2 hrs. or....min.?

CUPATION:
) Trade, profession, or particular kind of work: none
) General nature of industry, business, or establishment in which employed (or employer): ...do.

IRTHPLACE, State or Country), Center Bay

10-NAME OF FATHER, Homer A. Hammer

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Harriett J. Duncan

13-BIRTHPLACE OF MOTHER (State or Country), N Y

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Homer A Hammer

(Address) Center Bay

15- SEP 24 1920 Robert P. Harrison,
Dec. 4, 191....
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept 24, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 4 1920, to Sept 24 1920, that I saw h— alive on Sept 24 1920, and that death occurred, on the date stated above, at 4.30a m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Chas W Brooke M. D.

Sept 24, 1920 (Address) Brooklyn Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cemetery	Sept. 25, 1920
20-UNDERTAKER John F. Denny	ADDRESS 715 Light

(Kribbiel)

—H. P. Co.—1000 Eks.

6780 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46780

CERTIFICATE OF DEATH.

40

PLACE OF DEATH

BALTIMORE: (No. Franklin Square Hospital St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Mrs. Minnie Knabel

RESIDENCE. No. 111 Ostend St. St., WARD.
(Usual place of abode)

of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Married

married, widowed, or divorced HUSBAND of WIFE of Adolph Kribbiel

DATE OF BIRTH (month, day, and year) April 11th Apr. 11, 1852

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	5	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Adolf Kribbiel

(Address) 111 E. Ostend St.

15 SEP 24 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1920, to Sept 23, 1920

that I last saw h. alive on Sept 23, 1920

and that death occurred, on the date stated above, at 12.15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Starvation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lyman A. Abbott, M. D.

, 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	Sept 25 1920
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1422 Light St.

9—H. P. Co.—1000 Bks.

6781 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46781

CERTIFICATE OF DEATH. 119

PLACE OF DEATH

BALTIMORE: (No. 2734 N. Calvert ST.: 12 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Nettie Killing Lansdale

RESIDENCE. No. 2734 N. Calvert ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
le	white	married

Married, widowed, or divorced (or) WIFE of John M. Lansdale

DATE OF BIRTH (month, day, and year) Jan. 14. 1868

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	8	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Killing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Shores

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John M. Lansdale

(Address) 2734 N. Calvert

15 Filed SEP 24 1920 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22. 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 —, 19 20, to Sept 22, 19 20, that I last saw her alive on Sept 22, 19 20, and that death occurred, on the date stated above, at 3.30P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis —

(duration) yrs. 3 wks — ds.

CONTRIBUTORY (Secondary) Acute Rheum. —

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Penna.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Usual —

(Signed) Harold Brunner, M. D.

, 19 (Address) 125 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Sep. 25 1920

20 UNDERTAKER	ADDRESS
H. E. Hughes	17 S. Broadway

9—H. P. Co.—1000 Blks.

782 HEALTH DEPARTMENT—CITY OF BALTIMORE 2246782

CERTIFICATE OF DEATH.

92 REGISTERED NO.

PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

BALTIMORE: (No. 815. S Dallas St. 3 WARD)

FULL NAME Giuseppa. Trocki

RESIDENCE. No. 815 S. Dallas ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male.	White	Single.

If married, widowed, or divorced
(Wife of) HUSBAND of
(Husband of) or) WIFE of

DATE OF BIRTH (month, day, and year) August 17-1920

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	7	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Frank Trocki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Aniela Widowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Frank Trocki
(Address) 815 S Dallas

15 Filed SEP 25 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1920, to Sept 23, 1920, that I last saw h[illegible] alive on Sept 23, 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Dialysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Rosen M. D.

9/24/20 (Address) 808 N Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL Sept 25 1920

20 UNDERTAKER W H Frackowiak ADDRESS 168 Cowdery

-19-13--M. & T.—500 Bks.

2783 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046783

CERTIFICATE OF DEATH.

PLACE OF DEATH

REGISTERED No. C 647

OF BALTIMORE: (No. 2657 Frederick ave ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Marie L Paul

ence in Baltimore: No. 2657 Frederick ave St.; 35 yrs.. mos. da.)

ERSONAL AND STATISTICAL PARTICULARS.

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Marrie

E OF BIRTH, Dec 31 (Month) (Day), 1854 (Year)

E, 66 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

CUPATION:
) Trade, profession, or particular kind of work Hous
) General nature of industry, business, or establishment in which employed (or employer) 637

IRTHPLACE, State or Country England

10-NAME OF FATHER, John Hobbs

11-BIRTHPLACE OF FATHER (State or Country) England

12-MAIDEN NAME OF MOTHER Ann Thornthwaite

13-BIRTHPLACE OF MOTHER (State or Country) England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Paul

(Address) 2657 Frederick ave

15-

Filed SEP 25 1920, 191.. Burial Permit Clerk.

Registrar. Robert P. HARRISON

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 24 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 23 1920, to September 24 1920, that I saw h[illegible] alive on September 24 1920, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Coma

(Duration) yrs. mos. 1 ds.

(Signed) Upsom Westbrook M. D.

Sept 25 1920 (Address) 1667 Frederick ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Sept 27, 1920

20-UNDERTAKER MR. & MRS. N. S. FINK, FUNERAL DIRECTORS 2661 FREDERICK AVENUE

ADDRESS

9—H. P. Co.—1000 Blks.

6784 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46784

151

CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. 3740 Hickory Ave ST.; 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Albert W. Patterson

RESIDENCE. No. 3740 Hickory Ave ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

If married, widowed, or divorced
WIFE of HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) July 13, 1920

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank W. Patterson

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Shaffer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Frank W. Patterson
(Address) 3740 Hickory Ave

15 Filed 25 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1920, to Sept. 24, 1920, that I last saw him alive on Sept. 23, 1920, and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Martin, M. D.

, 19 (Address) 4119 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Hampden

DATE OF BURIAL SEP 25 1920

20 UNDERTAKER J. Walter Davis

ADDRESS 3307 Paine St

46785 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.46785

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE (No. Maryland Gen. Hosp. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Spurrier

Residence in Baltimore: No. 1117 Woodbridge St.; yrs. 47 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, Sept. 22, 1873
(Month) (Day) (Year)

7-AGE, 47 yrs. mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Electrical worker
(b) General nature of industry, business, or establishment in which employed (or employer): Oil

9-BIRTHPLACE, (State or Country), Ba. Co. Md.

PARENTS.

10-NAME OF FATHER, Nelson Spurrier

11-BIRTHPLACE OF FATHER (State or Country), Ba. Co. Md.

12-MAIDEN NAME OF MOTHER Julia Steiger

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Gross

(Address) 1806 E. Eager St.

15- Filed Sept 25, 1920, 191.... Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 22, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) ....No history

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. J. D. Hennessy M. D.
(Coroner.)

Sept. 24, 1920 (Address) 1532 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos. 1 ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? 1117 Woodbridge St.

Former or usual residence 1117 Woodbridge St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Sept 25, 1920
20-UNDERTAKER Wenman Cook	ADDRESS 502 E North Ave

6786 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46786

CERTIFICATE OF DEATH.

182

REGISTERED No. C.

1-PLACE OF DEATH

OF BALTIMORE (No. Franklin St Hospital ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob A Smith

Residence in Baltimore: No. 936 Franklin Rd. (Or Length of Time Resident in Baltimore: St.; yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Nov (Month) 8 (Day), 1858 (Year)

7-AGE, 62 yrs. 10 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balt City

PARENTS.

10-NAME OF FATHER, Charles Smith

11-BIRTHPLACE OF FATHER (State or Country). Balt City

12-MAIDEN NAME OF MOTHER Mary Knox

13-BIRTHPLACE OF MOTHER (State or Country). Balt City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles H Smith

(Address) 936 Franklin Rd

15-

Filed Sept 25 1920 Robert P. Harrison, 191.... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound in abdomen
Perforating the Stomach
Liver

(Duration).....yrs.....mos. 12 hrs

CONTRIBUTORY (Secondary) Incidental Hemorrhage

(Duration).....yrs.....mos. 12 hrs

(Signed) James H. Feeb M. D.
(Coroner.)

Sept 24 1920 (Address) 202 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Franklin Road

Former or usual residence 936 Franklin Rd

19-PLACE OF BURIAL OR REMOVAL, Ridge Cemetery Balto Co. DATE OF BURIAL, Sept 25, 1920

20-UNDERTAKER William Cook ADDRESS 202 E North

—H. P. Co.—1000 Ekz.

HEALTH DEPARTMENT—CITY OF BALTIMORE

280 — 946787

CERTIFICATE OF DEATH.

REGISTERED NO. 946787

PLACE OF DEATH

BALTIMORE: NO. Johns Hopkins Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Helen Williams.

RESIDENCE. NO. 1902 N. Gay St. Baltimore Md. WARD.

(Usual place of abode) (If nonresident give city or town and State)

If residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

If married, widowed, or divorced
(Of) HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) June 24-1913

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
7	3	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pennsylvania

10 NAME OF FATHER John Williams.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mark Cale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant John B. Williams (Address) 1902 N. Gay

15 Filed SEP 25 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1920, to Sept. 23, 1920, that I last saw h[er] alive on Sept. 23, 1920, and that death occurred, on the date stated above, at 10:45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) W. C. Dawson, M. D.

, 19 (Address) J H H Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore.

DATE OF BURIAL Sept 27 1920

20 UNDERTAKER William Cook

ADDRESS 501 E Nor

4-14—M. & T.—2000 Bks.

6788 HEALTH DEPARTMENT—CITY OF BALTIMORE 2.46788

CERTIFICATE OF DEATH.

10-28-91V

PLACE OF DEATH

REGISTERED No. C.....

OF BALTIMORE: (No. Maryland Penitentiary ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Mc. Kinley Chapman

ence in Baltimore: No. ..... St.: 1 yrs. ..... mos. ..... ds.)

ERSONAL AND STATISTICAL PARTICULARS.

	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	Black	Single

E OF BIRTH, March - 23, 1897
(Month) (Day) (Year)

E, 23 yrs. 5 mos. 28 ds. | If LESS than 1 day, ... hrs. or .... min.?

CUPATION:
) Trade, profession, or particular kind of work ..... General
) General nature of industry, business, or establishment in which employed (or employer) ..... Laborer

IRTHPLACE, State or Country), Virginia

10-NAME OF FATHER, Charley Chapman

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Betty Hall

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Patrick J. Brady

(Address) Md. Penitentiary

15-

Filed ..... 191.....

P 25 1920

Robert P. Harrison,
Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September - 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July - 22 1920, to September-21 1920, that I saw him alive on September - 20 1920, and that death occurred, on the date stated above, at 2304, m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation -
Edema of Lungs
(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia
(T.B.) (Duration) ..... yrs. 2 mos. ..... ds.

(Signed) William F. Schwark M. D.

9/21, 1920 (Address) Md. Penitentiary.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. 10 mos. 20 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Baltimore County, Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Asbury Dem	Sept 23, 1920
20-UNDERTAKER	**ADDRESS**
Sam'l W. Chase Son	1400 Hooker

4-14—M. & T.—2000 Bks.

789 HEALTH DEPARTMENT—CITY OF BALTIMORE 2046789

CERTIFICATE OF DEATH. ×129 REGISTERED NO. C

PLACE OF DEATH Providence Hosp.

OF BALTIMORE: (No. 4134 Biddle ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Julia Virginia White

nce in Baltimore: No. 316 N. Mount St.; ..... yrs., ... mos. 8 ds.)

ERSONAL AND STATISTICAL PARTICULARS.

	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
7	C	M

E OF BIRTH, April 8, 1887
(Month) (Day) (Year)

If LESS than 1 day, ...hrs. or.....min.?

33 yrs. 5 mos. 15 ds.

CUPATION: Trade, profession, or particular kind of work ..... Wife
General nature of industry, business, or establishment in which employed (or employer) .....

RTHPLACE, tate or Country), Calvert Co Md.

10-NAME OF FATHER, William Parker

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Martha Brown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David White

(Address) 316 N. Mount St

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

25 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 23, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 21 1920, to Sept 23 1920, that I saw h[illegible] alive on Sept 23 1920, and that death occurred, on the date stated above, at 8.40 P m.

The CAUSE OF DEATH* was as follows:

Myoma Uterus - Hypertrophied
Cystic Degeneration Rt. Ovary - ? (Duration) 1 yrs. ..... mos. ..... ds.
Anaemia - Severe

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. 1/2 ds.

Post Mortem

(Signed) Wm H Wright M. D.

Sept 27, 1920 (Address) 1204 Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. 8 ds.

Where was disease contracted, if not at place of death? Calvert Co. Md. Calvert

Former or usual residence 316 N. Mount.

19-PLACE OF BURIAL OR REMOVAL, Parkers Wharf Calvert Co

DATE OF BURIAL, Sept 23, 1920

20-UNDERTAKER Sam'l H. Frazier Son

ADDRESS 1400 Mosher

46790 HEALTH DEPARTMENT--CITY OF BALTIMORE D. 46790

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. Washington Road near Union Ave ST.: 25 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John. H. Thompson

Residence in Baltimore: No. Harvard Park Washington Blvd (3-12 yrs. 10 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~SINGLE~~ MARRIED ~~WIDOWED~~ OR ~~DIVORCED~~ (Write the word): Married

DATE OF BIRTH: Oct (Month) 6 (Day), 1867 (Year)

AGE: 52 yrs. 10 mos. 17 ds. — If LESS than 1 day, ... hrs. or ..... min.?

7 OCCUPATION
(a) Trade, profession, or particular kind of work: Commissioner
(b) General nature of industry, business, or establishment in which employed (or employer): City

8 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: William Thompson

11 BIRTHPLACE OF FATHER (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (State or country): Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Janelda Thompson

(Address) Harvard Park

15 Robert F. Harrison,

Filed SEP 25 1920, 191 Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 23 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to Sept 23 1920, that I saw h[e] alive on Sept 23, 1920, and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 2 mos. ds

Contributory (SECONDARY) Uremia

(Duration) yrs. mos. 4 ds.

(Signed) Gertrude E Lee M. D.

Sept 23 1920 (Address) Mt Lee Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mount Wm Cem Co — DATE OF BURIAL: Sept 27 1920

20 UNDERTAKER: for Joerdens Son — ADDRESS: 217 S Paca

—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

76791 — 92 L 46791

REGISTERED NO.

PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

BALTIMORE: (No.) Johns Hopkins Hospital ST.: (15 WARD)

FULL NAME Esther B. Forester

RESIDENCE. NO. 1343 N Wood Sglar St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single.

Married, widowed, or divorced
(Husband of
(or) Wife of

DATE OF BIRTH (month, day, and year) June 2 - 1902

If LESS than 1 day, hrs. or min.	Days	Months	Years
	14	4	18

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland.

10 NAME OF FATHER Richard Forester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Viola Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address)

15 Filed SEP 25 1920 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16 1920, to Sept. 23 1920, that I last saw her alive on Sept. 23 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Ovid

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. R. Mason, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: SEP 25 1920

20 UNDERTAKER: JAMES H. DENNIS — ADDRESS: 1303 PRESTMAN ST.

Burial Permit Clerk.

H. P. Co.—1000 Blks.

4792 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46792

120

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

BALTIMORE: (No. 614 Brune ST.: 17 WARD)

FULL NAME Julia Burke

RESIDENCE. No. 614 Brune ST., WARD.

(Usual place of abode)

of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col.	Wor.

Married, widowed, or divorced WIFE of (or) HUSBAND of Wm A Burke

DATE OF BIRTH (month, day, and year) Dec 1874

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Towson Md.

10 NAME OF FATHER Jos Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant W A Burke

(Address) 614 Brune

SEP 25 1920 Robert P. Harrison, Registrar

Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 19 20, to Sept 22, 19 20, that I last saw h... alive on Sept 22, 19 20, and that death occurred, on the date stated above, at 12 30 p m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Acute Uremia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No,

Was there an autopsy? Clinical

What test confirmed diagnosis?

(Signed) H Norwood, M. D.

, 19 (Address) 937 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 19 20

20 UNDERTAKER Samuel J Lemmon ADDRESS 578 W Pratt

...—H. P. Co.—1000 Bks.

6793 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46793

CERTIFICATE OF DEATH. 139

REGISTERED NO.....

PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (No.) 1315 E. Madison ST.: 10 WARD)

FULL NAME Mary L. G. Morgan

RESIDENCE. NO. 1315 E. Madison ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

...of residence in city or town where death occurred 34 yrs. 8 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Married

...married, widowed, or divorced (HUSBAND of (or) WIFE of Winfield B. Morgan

DATE OF BIRTH (month, day, and year) Jan. 1st 1886

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	8	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER James Cummings

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary L Rock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

PARENTS

14 Informant Mr Winfield B Morgan

(Address) 1315 E Madison St

15 Filed SEP 25 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1920, to Sept 24, 1920, that I last saw her alive on Sept 24, 1920, and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation &
Arteriosclerosis
probably dilated & embolic causes
Sudden dead (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mrs Morgan died Sudden
Cyanosis 1st stage of (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? nr

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wesley L Edwards, M. D.

, 19 (Address) 1038 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mem Cathedral Cemetery	Sept 27 1920
20 UNDERTAKER Henry Storck & Son	ADDRESS 1301 E Fayette

—H. P. Co.—1000 Blks.

794 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46794

CERTIFICATE OF DEATH.

40

PLACE OF DEATH

BALTIMORE: (No.) 2147 N. Amity (St.) 18 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Lillie Hall

RESIDENCE. No. 2147 Amity St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

(If married, widowed, or divorced) (HUSBAND of (or) WIFE of)

DATE OF BIRTH (month, day, and year) Sept 20 1879

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41		1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Md.

10 NAME OF FATHER: John Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Georgia Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Georgia Hall

(Address) 2148 Amity St.

15 Filed SEP 25 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1920, to Sept 21, 1920, that I last saw her alive on Sept 20, 1920, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 214 Amity St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. R. Coasey, M. D.

, 19 (Address) 733 George St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Sept 24 1920
20 UNDERTAKER	ADDRESS
Brown and Richardson	Catonsville

6795

D.46795

19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

PLACE OF DEATH

OF BALTIMORE (No. 257 E. Hamburg ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Catherine Cannon

RESIDENCE. No. 257 E. Hamburg ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	—

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

7 DATE OF BIRTH (month, day, and year) Dec 3 1919

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) / None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Clarence G. Cannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Sadie Fox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Sadie Cannon

(Address) 257 W. Hamburg

15 Filed SEP 25 1920 Robert F. Harrison Registrar

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1920, to Sept 24, 1920, that I last saw h[illegible] alive on Sept 24, 1920, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Asthma

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Gastro Enteritis

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Bellulla M. D.

9/24, 1920 (Address) 1249 Hillman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Sept 25 1920
20 UNDERTAKER	ADDRESS
F. C. Haas - Son	737 Hanover

19—H. P. Co.—1000 Bks.

6796 HEALTH DEPARTMENT—CITY OF BALTIMORE D.4,6796

CERTIFICATE OF DEATH. X 109

PLACE OF DEATH So. Balto. Gen. Hospital REGISTERED NO.

OF BALTIMORE: (No. 1213 Light ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Alice Brittingham

RESIDENCE. NO. 530 Sharp ST., WARD Roanoke Ind.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

6 If married, widowed, or divorced WIFE of (or) HUSBAND of Wm Brittingham

7 DATE OF BIRTH (month, day, and year) Jan. 2/1862

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	9	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset Co Md

10 NAME OF FATHER James Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lavenia Gravenor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

PARENTS

14 Informant Bernice Ritchie
(Address) 530 A Sharp St.

15 FEB 25 1920 19 Robert P. Harrison, Registrar
Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1920

17 I HEREBY CERTIFY, That I attended deceased from ..... 19..... to Sept. 24. 1920.
that I last saw her alive on Sept. 24. 1920.
and that death occurred, on the date stated above, at 5.50P m.

The CAUSE OF DEATH* was as follows:

Ventral Hernia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Surg. shock.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Sept 23, 20
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) J. E. Ponte Jr. M. D.
(Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pocomoke Worc. Co Md — DATE OF BURIAL Sept 25 1920

20 UNDERTAKER F. A. Krause & Son — ADDRESS 703 Hanover

24-14—M. & T.—2000 Bks.

2797 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.46797

113

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

PLACE OF DEATH
OF BALTIMORE: (No. 2006 Greenmount Ave. ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Vincenzo Castiglione

Residence in Baltimore: No. 2006 Greenmount ave St.; 2 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3—SEX: Male

4—COLOR OR RACE: White

5—~~SINGLE, MARRIED, WIDOWED, DIVORCED.~~ (Write the word.): widower

6—DATE OF BIRTH: May 2, 1857 (Month) (Day) (Year)

7—AGE: 63 yrs. 4 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8—OCCUPATION: (a) Trade, profession, or particular kind of work: housekeeper (b) General nature of industry, business, or establishment in which employed (or employer): Home

9—BIRTHPLACE, (State or Country): Italy

10—NAME OF FATHER: Gaetano Sorendi

11—BIRTHPLACE OF FATHER (State or Country): Italy

12—MAIDEN NAME OF MOTHER: Nunzia Portary

13—BIRTHPLACE OF MOTHER (State or Country): Italy

14—THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Castiglione

(Address) 2006 Greenmount ave

15—Filed SEP 25 1920, 191.. Robert P Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16—DATE OF DEATH, Sept. 24, 1920 (Month) (Day) (Year)

17—I HEREBY CERTIFY, That I attended deceased from ~~Oct. 6~~ 1920, to Sept 24 1920, that I saw h~~e~~r alive on Sept 24 1920, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Sclerosis of the liver

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Charles Lesh M. D.

, 191... (Address) 710 Pearl st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18—LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19—PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. | DATE OF BURIAL, Sept 27, 1920

20—UNDERTAKER John J Cowan & Son | ADDRESS 901 Hollins st

9—H. P. Co.—1000 Bks.

6798

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46798

CERTIFICATE OF DEATH.

99

PLACE OF DEATH

BALTIMORE: (No. 617 S Glover ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Frank A Stralecki

RESIDENCE. No. 617 S Glover ST. 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 6-1920

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Md U S A

PARENTS

10 NAME OF FATHER John Fralecki

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md U S A

12 MAIDEN NAME OF MOTHER Martha Ensemsha

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md U S A

14 Informant John Fralecki
(Address) 617 S Glover St

SEP 25 1920 19

Registrar

Postal Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 23 1920, to Sept 24 1920, that I last saw him alive on Sept 23 1920, and that death occurred, on the date stated above, at 3 30 p m.

The CAUSE OF DEATH* was as follows:

Parasitic Stomatitis (Thrush)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) — yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death? Dr Michaels Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) A A Brudrick, M. D.

19 (Address) 122 E Patterson Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Sept 26 1920
20 UNDERTAKER Stephen J Falkowski	ADDRESS 1005 Hanover

d. 46799

9—H. P. Co.—1000 Bks.

799 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No.) 2610 Hudson ST.: ( ) WARD)

FULL NAME Stephen Milenka

RESIDENCE. NO. 2610 Hudson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

(If married, widowed, or divorced) (HUSBAND) of (or) (WIFE) of

6 DATE OF BIRTH (month, day, and year) Aug 31 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	—	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Southern Can Co

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer Smith

BIRTHPLACE (city or town) (State or country) Poland Balto

10 NAME OF FATHER Stephen Milenka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Sadawska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stephen Milenka (Address) 2610 Hudson St

15 Filed SEP 25 1920 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 19 20

17 I HEREBY CERTIFY, That I attended deceased from Sept 22 19 20 to Sept 22 19 20

that I last saw him alive on Sept 22 19 20

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Septic Endocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Dilatation of heart

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Dr Mohr.

(Signed) Maxwell L Magers M. D.

19 (Address) 3115 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus DATE OF BURIAL Sep 27 1920

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

9—H. P. Co.—1000 Blks.

800 HEALTH DEPARTMENT—CITY OF BALTIMORE 246800

CERTIFICATE OF DEATH. x 33

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

FULL NAME Mrs Sue Gray Dunnington

RESIDENCE. No 207 West 6th St Columbia Tenn. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)
of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

Married, widowed, or divorced (or) HUSBAND of (or) WIFE of Widowed

DATE OF BIRTH (month, day, and year) Aug 26. 1844

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
76	76	1		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Tenn.

10 NAME OF FATHER Albert Booker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn

12 MAIDEN NAME OF MOTHER Ruth Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn.

14 Informant Mrs W. S. Fleming (Address) Columbia Tenn.

15 Filed SEP 25 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 22 1920, to Sept 24- 1920, that I last saw her alive on Sept 24- 1920, and that death occurred, on the date stated above, at 10-P- m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Hip

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Tenn.

Did an operation precede death? yes Date of July 26, 1920

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Allen H Buckell, M. D.

9/24/1920 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Nashville Tenn

DATE OF BURIAL Sept 25 1920

20 UNDERTAKER H. Sander Sons

ADDRESS 1710 Eutaw

9—H. P. Co.—1000 Bks.

801 HEALTH DEPARTMENT—CITY OF BALTIMORE 46801

CERTIFICATE OF DEATH. 164

PLACE OF DEATH

BALTIMORE: (No. New City Hospital ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Frank Wallace

RESIDENCE. No. 524 S. Green St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
e	Colored	Married

married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

TE OF BIRTH (month, day, and year) 1865

E	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Frank Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed SEP 26 1920 ROBERT F. [illegible]
Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22. 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 18, 1920. to Sept. 22. 1920.
that I last saw h.. im alive on September 21. 1920.
and that death occurred, on the date stated above, at 7:10 A. m.
The CAUSE OF DEATH* was as follows:

Botulism

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Paralytic Illeus

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? 524 S. Green St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) H. B. Wetman M. D.

9/22/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetary	Sept 26 1920
20 UNDERTAKER	ADDRESS
Clement Hall	1945 Penna Ave

24-14—M. & T.—2000 Bks.

6802 HEALTH DEPARTMENT—CITY OF BALTIMORE 46802

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

PLACE OF DEATH

OF BALTIMORE: (No. 933 Park ave St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Thomas Carr

ence in Baltimore: No. 933 Park Ave St.; 72 yrs.....mos.....ds.)

ERSONAL AND STATISTICAL PARTICULARS.

M | 4-COLOR OR RACE, Colored | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

TE OF BIRTH, Aug 1, 1872 (Month) (Day) (Year)

E, 35 yrs. 1 mos. 15 ds. | If LESS than 1 day, ...hrs. or.....min.?

CUPATION:
) Trade, profession, or particular kind of work..... Laborer
) General nature of industry, business, or establishment in which employed (or employer)..... Do

IRTHPLACE, State or Country), Virginia

10-NAME OF FATHER, Allen Carr

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Fannie Reard

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Delia Carr Wife

(Address) 933 Park Ave.

15- SEP 26 1920 ROBERT B KRAUTER

Filed....., 191..... Registrar.

BURIAL PERMIT ISSUED

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 24th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 18th 1920, to Sept 24 1920, that I saw h[illegible] alive on Sept 24 1920, and that death occurred, on the date stated above, at 6.15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) None known

(Duration) yrs. mos. ds.

(Signed) Chas. E. Keller M. D.

Sept 25, 1920 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery | DATE OF BURIAL, Sept 26, 1920

20-UNDERTAKER Jno M. Johnson | ADDRESS 1231 Ettring St

4-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

803

CERTIFICATE OF DEATH.

28 46803

REGISTERED NO. C

PLACE OF DEATH
OF BALTIMORE: (No. 815 N. Caroline ST.; 7 WARD)

FULL NAME Grace Beatrice Jefferies

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

ence in Baltimore: No. 815 N. Caroline St.; Life time (yrs., mos., ds.)

ERSONAL AND STATISTICAL PARTICULARS.

	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

E OF BIRTH, Jan. (Month) 16 (Day), 1900 (Year)

E. 20 yrs. 8 mos. 8 ds. | If LESS than 1 day, ...hrs. or.....min.?

CUPATION:
Trade, profession, or particular kind of work: Seamstress
General nature of industry, business, or establishment in which employed (or employer):

IRTHPLACE, tate or Country), Baltimore Md.

10-NAME OF FATHER, Samuel N. Rollison

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Selena Yerkes

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Selena Rollison

(Address) 815 N. Caroline st

15- SEP 26 1920 ROBERT F. KRAUTER

Filed....., 191.... Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 24 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1920, to Sept 24 1920, that I saw h[illegible] alive on Sept 20 1920, and that death occurred, on the date stated above, at 7.50 a m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John F. Weis M. D.

Sept 24 1920 (Address) 1936 Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem

DATE OF BURIAL, Sept 27, 1920

20-UNDERTAKER H. Allen Fuller

ADDRESS 3517 Eastern Ave

Dr Hecht mounted + Emb

9—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1804 — 1946804

CERTIFICATE OF DEATH.

REGISTERED NO. 92

PLACE OF DEATH

BALTIMORE: (No. 316 S. Vincent St. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Mamie ELizabeth Sutton

RESIDENCE. NO. 316 S. Vincent St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

If of residence in city or town where death occurred, how long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
le.	Negro	Married.

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Lawrence A. Sutton 1891 1941

7 DATE OF BIRTH (month, day, and year) Sept. 17, ~~1891~~

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
29		0	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md.

12 MAIDEN NAME OF MOTHER Mary Carrol

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md.

14 Informant Lawrence Sutton. (Address) 300 S. Vincent st

15 Filed SEP 26 1920 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 23, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3rd. 1920, to Sept. 23 1920, that I last saw her alive on Sept. 23, 1920, and that death occurred, on the date stated above, at 5:00 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Bilateral)

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter D. Jackson, M. D.

(Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Star Cem. DATE OF BURIAL: Sept 28, 20

20 UNDERTAKER: A. Jones ADDRESS: 207 S. Stricker st

9—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

6805 — 046805

CERTIFICATE OF DEATH.

REGISTERED NO. 79

PLACE OF DEATH

IF BALTIMORE: No. 1706 Ashland Ave. ST.; or WARD)

FULL NAME Adolph L. Baer

RESIDENCE. No. 1706 Ashland Ave. ST. WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Baer.

6 DATE OF BIRTH (month, day, and year): Oct 5, 1848

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	11	20	

7 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Cabinet-Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 1914

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Julia Baer (Address) 1706 Ashland Ave.

15 Filed SEP 26 1920 ROBERT B. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 25 1920

17 I HEREBY CERTIFY, That I attended deceased from September 20, 19 20, to Sept 25, 19 20

that I last saw him alive on Sept 24, 19 20

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis 2 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Adolph A. Mayer, M. D.

25, 19 20 (Address) 1031 N. Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Army — DATE OF BURIAL: Sept 27 19

20 UNDERTAKER: Windell Carpenter & Son — ADDRESS: 870 N.

9—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 1046806

6806

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

(a) BALTIMORE: (No. 535 S Carlton St. 3 WARD)

(b) FULL NAME James Hogan

(c) RESIDENCE. No. 535 S Carlton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Infant

married, widowed, or divorced
(HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 18 1920

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			7	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Jack Hogan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Florida

12 MAIDEN NAME OF MOTHER Flarnce Thurstand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Florida

14 Informant Jane Hogan
(Address) 535 S Carlton

15 Filed SEP 26 1920 ROBERT J. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 22 20, to Sept 25 1920, that I last saw her alive on Sep 24 1920, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J R Jones M. D.

19 (Address) 2338 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenly

DATE OF BURIAL Sep 26 1920

20 UNDERTAKER Wendell Bryce & Son

ADDRESS 324 N

807

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 046807

REGISTERED No. C

PLACE OF DEATH

OF BALTIMORE: (No. Hebrew Hospital ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Samuel Wyman

Idence in Baltimore: No. 2018 Christian St St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	White	Married

TE OF BIRTH Dec 9 (Month) 1872 (Day) (Year)

GE, 47 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

CCUPATION:
a) Trade, profession, or particular kind of work Presser
b) General nature of industry, business, or establishment in which employed (or employer) Clothing

BIRTHPLACE, State or Country), Russian

10-NAME OF FATHER, Yosel Lail Wesman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Annie —

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1411 E Balto St

15 SEP 26 1920 ROBERT B. LAUTER

Filed....., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 27th., 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/9 1920, to 9/27 1920, that I saw h[illegible] alive on 9/27 1920, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 7 ds.

(Signed) B. Sacks M. D.

....., 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 15 ds. In the State 18 yrs. mos. ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 2018 Christian St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Wash Rd

DATE OF BURIAL, Sept 29th., 1920

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto St

-8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46808

6808

CERTIFICATE OF DEATH.

REGISTERED NO. C 35

1-PLACE OF DEATH

OF BALTIMORE: (No. 1363 Gilmor North ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Geneva Disney

idence in Baltimore: No. 1363 Gilmor st (North) St.; 30 yrs., ✓ mos. ✓ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

X. female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

TE OF BIRTH, May (Month) 26 (Day), 1877 (Year)

GE, 43 yrs. 3 mos. 28 ds. | If LESS than 1 day, ..hrs. or ✓ min.?

CCUPATION:
a) Trade, profession, or particular kind of work: Housekeeper
b) General nature of industry, business, or establishment in which employed (or employer):

IRTHPLACE, (State or Country) Anne Arundel Co. Md.

10-NAME OF FATHER, William Watts Wm. Watts

11-BIRTHPLACE OF FATHER (State or Country) Anne Arundel Co Md

12-MAIDEN NAME OF MOTHER Irene Chaney

13-BIRTHPLACE OF MOTHER (State or Country) Anne Arundel Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine Womack

(Address) 9 Prospect Circle

15- SEP 26 1920 Filed....., 191.. ROBERT B KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 24 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mch 3. 1919, to Sept 24 1920, that I saw h[er] alive on Sept 18 1920; and that death occurred, on the date stated above, at 10 30 p m.

The CAUSE OF DEATH* was as follows: See back of certificate

Tuberculosis General

(Duration) 2 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Hemorrhage Pulmonary

(Duration) ✓ yrs. ✓ mos. 1 ds.

(Signed) George C. Shannon M. D.

Sept 24, 1920 (Address) 700 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery | DATE OF BURIAL, Sept 27, 1920

20-UNDERTAKER Geo. Albert & Son | ADDRESS 2503 Edmondson Ave

24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

809 151 1946809

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH
OF BALTIMORE: (NO. 1023 E. Lombard st ST.; 3 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Anna M. Vernacchia
ence in Baltimore: No. 1023 E. Lombard st St.; ...yrs.. mos. 26 ds.)

ERSONAL AND STATISTICAL PARTICULARS.

	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
fem	white	

TE OF BIRTH, Aug. 29, 1920
(Month) (Day) (Year)

E, ...yrs. 26 mos. ...ds. | If LESS than 1 day, ...hrs. or ...min.?

CCUPATION:
) Trade, profession, or particular kind of work
) General nature of industry, business, or establishment in which employed (or employer)

IRTHPLACE, State or Country), Balto

10-NAME OF FATHER, Felice Vernacchia

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Teresa Saracalli

13-BIRTHPLACE OF MOTHER (State or Country), Italy

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Felix Vernacchia

(Address) 1023 E Lombard St

15- SEP 26 1920 191... ROBERT F KRAUTER Registrar.
Filed Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sep. 25, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 29 1920, to Sep. 25 1920, that I saw h.r alive on Sep. 25 1920, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows: congenital debility
7 months term
(Duration) ...yrs. ...mos. 26 ds.

CONTRIBUTORY (Secondary)
(Duration) ...yrs. ...mos. ...ds.

(Signed) Charles Testa M. D.
..., 191... (Address) 210 Pearl st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincent Cem | DATE OF BURIAL. Sept 27, 1920

20-UNDERTAKER J. Ahrens & Co | ADDRESS 1611 Madison

19—H. P. Co.—1000 Blks.

6810 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046810

CERTIFICATE OF DEATH. 479

PLACE OF DEATH

OF BALTIMORE: (No.) 410-4150 W. Biddle ST.: 11 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Elvira M. Robinson

RESIDENCE. NO. Provident Hospital ST.. WARD. Daytona Fla.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

(If married, widowed, or divorced) HUSBAND of (or) WIFE of William D Robinson

6 DATE OF BIRTH (month, day, and year) July 20, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Trained Nurse.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Public — Atlanta Ga.

9 BIRTHPLACE (city or town) (State or country) Augusta Georgia

10 NAME OF FATHER Augustus Moore

11 BIRTHPLACE OF FATHER (city or town) Ga.

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Georgia

(State or country)

14 Informant William D Robinson Husband

(Address) 422 2nd St

15 SEP 26 1920 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1920, to Sept 25, 1920 that I last saw h.. alive on Sept 24, 1920, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 3 mos. 2 ds.

CONTRIBUTORY (Secondary) Adenitis - Mesenteric

(duration) yrs. 1 mos. 24 ds.

18 Where was disease contracted if not at place of death? Daytona Flor.

Did an operation precede death? No Date of

Was there an autopsy? No

What tests confirmed diagnosis? Physical Signs

(Signed) for Chas. W. Wright, M. D.

Sept 25, 1920 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Daytona Florida	Sept 28 1920
20 UNDERTAKER	ADDRESS
Samuel T Kemsley	5 E Biddle

9—H. P. Co.—1000 Bks.

46811 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46811

CERTIFICATE OF DEATH. 4 134

REGISTERED NO.

PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

BALTIMORE: (NO. University Hospital ST.: WARD: 4

FULL NAME Anna Long

RESIDENCE. NO. Cockeysville Md ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

If married, widowed, or divorced
(HUSBAND of or) WIFE of Frank Long.

6 DATE OF BIRTH (month, day, and year)

Years	Months	Days	If LESS than 1 day, hrs. or min.
28 years			

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

8 BIRTHPLACE (city or town) (State or country) Maryland

9 NAME OF FATHER Joe Brown

10 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

11 MAIDEN NAME OF MOTHER Martha Nese

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

13 Informant University Hospital Records.
(Address)

15 SEP 26 1920 ROBERT B. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1920, to Sept 24, 1920, that I last saw her alive on Sept 24, 1920, and that death occurred, on the date stated above, at 10.35 9 m.

The CAUSE OF DEATH* was as follows:

Pyaemia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Incomplete abortion

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept. 17, 1920

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Cyrus F. Hanine M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL

Jessup Church Sept 26 1920

20 UNDERTAKER ADDRESS

Wm. C. Brooks Sparks Md

19—B. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046812

6812

CERTIFICATE OF DEATH.

120

PLACE OF DEATH
OF BALTIMORE: (No. 221 W Madison St. WARD) 11

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Louisa Grauger

RESIDENCE. No. 221 W Madison St WARD.
(Usual place of abode)
(If nonresident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.
Length of residence in city or town where death occurred 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widower

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louis N Grauger Sr

7 DATE OF BIRTH (month, day, and year) Mar 12 1855

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	6	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hair Dresser
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia Pa
(State or country)

10 NAME OF FATHER Charles Leuzer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Eva Kreamer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Meta Grauger
(Address) 221 W Madison St

ROBERT F. KRAUTER
Registrar

15 Filed SEP 26 1920 19
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 2 1920 to Sept 24 1920.
that I last saw her alive on Sept 24 1920. 1.45 m.
and that death occurred, on the date stated above, at
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis
(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F Clautice M. D.
Sept 25 1920 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 27 1920
20 UNDERTAKER	ADDRESS
Graham & Wood	723 Lafayette

24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

10-46813

813.

CERTIFICATE OF DEATH.

15

REGISTERED NO. C.....

PLACE OF DEATH

OF BALTIMORE: (No. 1017 S Bouldin ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Baby Schisler (If not known, so state.)

Residence in Baltimore: No. 1017 S Bouldin St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	S

TE OF BIRTH. Sept 24, 1920
(Month) (Day) (Year)

E, ... yrs. 1 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

CUPATION:
) Trade, profession, or particular kind of work ..... Home
) General nature of industry, business, or establishment in which employed (or employer) .....

IRTHPLACE, State or Country). Baltimore Md

10-NAME OF FATHER. Philip Schisler

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Elizabeth Kalbfleisch

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Philip Schisler

(Address) 1017 S. Bouldin St.

15- Filed SEP 26 1920 ROBERT B KRAUTER Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 24, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 22 1920, to Sept 24 1920, that I saw h er alive on Sept 24 1920, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Premature birth
6-7 month uteri gestation
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leo A Lanahan M. D.

Sept 24 1920 (Address) 303 E Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cem. DATE OF BURIAL, Sept 26, 1920

20-UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Wolfe St.

24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

6814

CERTIFICATE OF DEATH.

28 2046814

REGISTERED NO. C.....

PLACE OF DEATH

OF BALTIMORE: (No. 323 N. Eppleton ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME John Louis Stump

dence in Baltimore: No. 323 N. Eppleton St., 39 yrs., 9 mos. 18 ds.)

ERSONAL AND STATISTICAL PARTICULARS.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

TE OF BIRTH, January 5, 1881.
(Month) (Day) (Year)

E, 39 yrs. 9 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

CCUPATION:
) Trade, profession, or particular kind of work..... Clerk
) General nature of industry, business, or establishment in which employed (or employer)..... Produce Market

IRTHPLACE, State or Country), Baltimore Md.

10-NAME OF FATHER, John Louis Stump

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Matilda Hindle

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md.

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Annie Hamilton

(Address) 913 W. Mulberry St.

SEP 26 1920

15- ROBERT J. LAUTER

Filed....., 191.....

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 23, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 18 1919, to Sept 23 1920, that I saw him alive on Sept 23 1920, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Tuberculosis

(Duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Robt J. Murray M. D.

Sept 25, 1920. (Address) 510 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Western Cemetery

DATE OF BURIAL: Sept. 27, 1920

20-UNDERTAKER: Chas. G. Black

ADDRESS: 742 W. North Ave

9—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46815 — 104 — 46815

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE. (No.) 2209 N Pratt ST. 20 WARD)

FULL NAME Baby Ethel L. Kuester

RESIDENCE. No. 2209 N. Pratt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

(If married, widowed, or divorced) WIFE of (or) HUSBAND of

DATE OF BIRTH (month, day, and year) June 8th 1920

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	3	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Henry H. Kuester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Schaefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Henry H. Kuester

(Address) 2209 N Pratt

15 Filed SEP 26 1920 ROBERT E. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1920, to Sept 25, 1920, that I last saw him alive on Sept 25, 1920, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Diarrhoea Enteritis

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wesley A Bof, M. D.

19 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Sept 1920

20 UNDERTAKER: F. B. Keppert — ADDRESS: 2336 Fred'k Ave

46816 HEALTH DEPARTMENT—CITY OF BALTIMORE 1946816

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. On R.R. Train B&O R.R. ST. 13 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew K. Martin

Residence in Baltimore: No. 2323 Linden ave. St.: 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct ....., 1860
(Month) (Day) (Year)

7-AGE, 59 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... R.R. Mail Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... B&O

9-BIRTHPLACE, (State or Country), W. Va.

PARENTS.

10-NAME OF FATHER, Isac Martin

11-BIRTHPLACE OF FATHER (State or Country), W. Va

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), W. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katharine A. Martin

(Address) 2323 Linden Ave

15- SEP 26 1920 ROBERT B KRAUTER Registrar.
Filed....., 191.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 24, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ..... yrs. 9 hrs mos. ..... ds.

CONTRIBUTORY (Secondary) Don't know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Gorsuch M. D.
(Coroner.)

9-24 1920 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Sept 27, 1920

20-UNDERTAKER John O. Mitchell

ADDRESS W. Lafayette

19—H. P. Co.—1000 Blks.

6817

HEALTH DEPARTMENT—CITY OF BALTIMORE

48 1046817

CERTIFICATE OF DEATH.

REGISTERED NO.

PLACE OF DEATH

OF BALTIMORE: No. 208 N. Gilmore ST.: 14 WARD.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Mary Evelyn Hill

RESIDENCE. No. 208 N. Gilmore ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 10 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: Female — White

5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed, or divorced WIFE of (or) HUSBAND of: Edward Hill

DATE OF BIRTH (month, day, and year): Oct 31. 1883

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	10	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House duties

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: Eugene R. Pruett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Emma T. Coulbourn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Edward Hill Sr.

(Address): 208 N. Gilmore St.

15 Filed SEP 26 1920 ROBERT E. REUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Mch 1, 1920, to Sept. 24, 1920, that I last saw h her alive on Sept 24, 1920 and that death occurred, on the date stated above, at 5:20 a.m.

The CAUSE OF DEATH* was as follows: Arthritis Deformans

over (duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Henry C. Olds, M. D.

Sept 25 1920 (Address) 1201 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept 27 1920

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W. Fayette St.

5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

6818 — 1046818

CERTIFICATE OF DEATH.

170

PLACE OF DEATH

REGISTERED No. C

OF BALTIMORE: (No. North ave Int Washington St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Herman Wagner

Residence in Baltimore: No. North ave Int Washington St.: 1 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Single

DATE OF BIRTH, — (Month) — (Day) 1859 (Year)

AGE, 61 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or ....min.?

OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Standard Oil Co

BIRTHPLACE, (State or Country): Md

10-NAME OF FATHER: August Wagner

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Emma Carl

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Adolph Wagner

(Address): 2838 St Paul St

15-

Filed SEP 26 1920 19.. EDW. F. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1919, to Sept. 25 1920, that I saw h me alive on Sept. 24 1920, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

(a) Chronic Interstitial Nephritis

(b)

(c)

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. H. Beeler M. D.

10.25., 1920 (Address) Int Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Sept 27 1920

20-UNDERTAKER John Mutchell ADDRESS 1201 W Fayette St

-19—H. P. Co.—1000 Blks.

6819 HEALTH DEPARTMENT—CITY OF BALTIMORE 120 2046819

CERTIFICATE OF DEATH.

REGISTERED NO.

PLACE OF DEATH

OF BALTIMORE: (NO. 514 N. Gilmore ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Aaron Wooden

) RESIDENCE. NO. 514 N. Gilmore ST.. WARD. Balto md

(Usual place of abode) (If nonresident give city or town and State)

th of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
ale	Colored	Married

married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year)

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	—	—	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Jessie Wooden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) JAMES H. DENNIS 1303 PRESTMAN ST.

15 Filed SEP 26 1920 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 23, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 19 —, 1920, to Sept. 23, 1920, that I last saw him alive on Sept. 23, 1920, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edw. F. Wheatley, M. D.

Sept 24 1920 Address) 1230 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL SEP 26 1920

20 UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST.

D46820 O.K.

9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6820

REGISTERED NO. 104

PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (No. 624 S Bond ST.: 3 WARD)

FULL NAME Lucian Bednarczyk

a) RESIDENCE. NO. 624 S Bond ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

gth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

X	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Child

married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Jan 7 1920

GE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	8.	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jakub Bednarczyk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Zlzgota

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Jakub Bednarczyk (Address) 624 S Bond

15 Filed SEP 26 1920 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16 1920, to Sept 24 1920, that I last saw him alive on Sept 24 1920, 4 PM and that death occurred, on the date stated above, at 4 PM

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion. (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed William J Romer, M. D.

(Address) 801 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Sept 26 1920

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

5-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

6821

CERTIFICATE OF DEATH.

40 046821

PLACE OF DEATH

REGISTERED NO. C.....

OF BALTIMORE: (No. 1829 Bank ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

-FULL NAME Agatha Mach

dence in Baltimore: No. 1829 Bank St.; 15 yrs., ... mos. ..... ds.)

ERSONAL AND STATISTICAL PARTICULARS.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

TE OF BIRTH, ... Unknown ....., 1 .....
(Month) (Day) (Year)

E, ...75.... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

CCUPATION:
) Trade, profession, or particular kind of work ..... House wife
) General nature of industry, business, or establishment in which employed (or employer) 3

IRTHPLACE, tate or Country), Poland

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Poland

4-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Mrs. Sarah Ri .....

(Address) 705 S. Ann St.

15- SEP 26 1920, 191.....

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Sept. 24 ....., 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 16 1920, to Sept 16 1920, that I saw h[illegible] alive on Sept 16 1920, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

.....

.....

Cancer of the Stomach

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Convulsions Eclampsia

..... (Duration) 1 yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Sept. 25, 1920 (Address) 722 S. Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus. DATE OF BURIAL, Sept. 27, 1920

20-UNDERTAKER, W. F. Sachowski ADDRESS 705 S. Ann

19—H. P. Co.—1000 Bks. Magdalena Wojtyszak.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46822 64 No. 46822

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. 5045 Montford Ave ST.: 1 WARD)

FULL NAME Magdalena Wojtyszak

RESIDENCE. NO. 504 S. Montford ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
	White	Widowed

If married, widowed, or divorced (or) WIFE of Wodenty Wojtyszak

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant M F Sadowski.
(Address) 705 S Ann St

15 Filed SEP 26 1920 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1920, to Sept 24, 1920, that I last saw her alive on Sept 14, 1920, and that death occurred, on the date stated above, at 12 M m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Uraemia & Cerebrosis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Edema Hemorrhage & Heart Failure (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptom

(Signed) Harry D Shultz, M. D.

9/25. 1920 (Address) 1623 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus.

DATE OF BURIAL Sept. 28 1920

20 UNDERTAKER M F Sadowski.

ADDRESS 705 S. Ann

-19—H. P. Co.—1000 Bks.

16823 HEALTH DEPARTMENT—CITY OF BALTIMORE 2046823

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

PLACE OF DEATH

OF BALTIMORE: (No. 1332 N. Caroline ST.) 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Hester A. Baxter

RESIDENCE. No. 1332 N. Caroline

(Usual place of abode) WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
	Female White	Widow

married, widowed, or divorced

(or) WIFE of John W. Baxter

DATE OF BIRTH (month, day, and year) July 23/38

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	2	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER John Berard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harriett Bell

(Address) 1332 N. Caroline

15 Filed SEP 26 1920 ROBERT P. LAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 11, 1920, to Sept 25, 1920, that I last saw h[illegible] alive on Sept 24, 1920, and that death occurred, on the date stated above, at 2 9, m.

The CAUSE OF DEATH was as follows:*

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 1107 Lemmington Bld

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem.	Sept 27 1920
20 UNDERTAKER	ADDRESS
Philip Herwig	2016 Orleans

0-19—H. P. Co.—1000 Eks.

6824 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 1046824

CERTIFICATE OF DEATH. 79 REGISTERED NO.....

PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (a) No. Earl Court ST.: 11 WARD)

FULL NAME. Richard H Spencer

(b) RESIDENCE. No. St Paul + Preston ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

(Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

married, widowed, or divorced WIFE of (or) HUSBAND of Alice H Spencer

ATE OF BIRTH (month, day, and year) 1834 Nov

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Talbot County

10 NAME OF FATHER Henry Spencer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anne Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbot County

14 Informant Alice H Spencer (Address) East Court

15 Filed SEP 26 1920 ROBERT E. LEE [illegible] Vital Record Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 20. 1920. to Sept 24 1920.

that I last saw him alive on Sept 24 1920.

and that death occurred, on the date stated above, at 8 A.M. / P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Myocardial Degeneration

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) Several mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Examination

(Signed) C. B. Gamble Jr. M. D.

. 19 (Address) 2402 Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem DATE OF BURIAL 9-27- 1920

20 UNDERTAKER: Henry W. Jenkins' Sons ADDRESS Orchard + Calhoun

19—H. P. Co.—1000 Bks.

6825 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046825

CERTIFICATE OF DEATH. 40

REGISTERED NO.

PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (No. St. Joseph's Hosp. ST.: 10 WARD)

FULL NAME Edward C. Sappington

RESIDENCE. No. 818 Eagar ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

(Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
ale	White	Married

married, widowed, or divorced
(or) HUSBAND of Mary Sappington

DATE OF BIRTH (month, day, and year) Feb 8 - 1878

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Expert Clerk

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER William Sappington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nellie Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Sappington

(Address) 818 E. Eager St

15 FILED SEP 26 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26 1920

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1920, to Sept. 26, 1920, that I last saw him alive on Sept. 26, 1920, and that death occurred, on the date stated above, at 3:00 A. m.

The CAUSE OF DEATH* was as follows:

General Carcinomata of peritoneal cavity.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Pylorus

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) J. B. Brumbaugh, M. D.

9-26-1920 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Harford Rd

DATE OF BURIAL Sept 29 1920

20 UNDERTAKER William Cook

ADDRESS 502 E North Ave

Burial Permit Clerk

...-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6826 — 46826 — 42

REGISTERED NO.

PLACE OF DEATH

OF BALTIMORE: (No.) New City Hospital (ST.:) 4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Mollie Flockenhagen

) RESIDENCE. NO. 311 N. Green St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

th of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Married

married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

ATE OF BIRTH (month, day, and year) 1875

GE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	45			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

10 NAME OF FATHER Henry Vox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Boston

12 MAIDEN NAME OF MOTHER Vergie Cimminghane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston

14 Informant (Address) Hospital Records, New City Hospital.

15 FI... SEP 26 1920 ... FRANCIS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1920. to Sept. 25, 1920.

that I last saw h er alive on September 24, 1920.

and that death ocrurred, on the date stated above, at 5:45 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia & cachexia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? microscopical section

(Signed) F. A. Holden, M. D.

9/25/20 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Acridental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Sept 27 1920
20 UNDERTAKER William Cook	ADDRESS S or E North

24-14—M. & T.—2000 11ks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

6827 — 1920 — 246827

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

PLACE OF DEATH
OF BALTIMORE: (No. 1315 E Balto St ST. 3 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Bessie Spector

Residence in Baltimore: No. 1315 E Balto St

St., 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female
4-COLOR OR RACE: White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widow

6-DATE OF BIRTH: Unknown (Month) ..... (Day) 1 (Year)

7-AGE: 71 yrs. — mos. — ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, State or Country): Russia

10-NAME OF FATHER: Nathan Cohen

11-BIRTHPLACE OF FATHER (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Ethel —

13-BIRTHPLACE OF MOTHER (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jack Lewis
(Address) 1441 E Balto St

15- Filed SEP 26 1920 191... Burial Permit Issued Registrar. BOPLEY & KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 26, (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 18 1919, to Sept. 26 1920, that I saw her alive on Sept. 25 — 1920, and that death occurred, on the date stated above, at 2:50 m.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
(Duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(Duration) yrs. mos. 2 ds.

(Signed) Nathan B. Bordeaux M. D.
9/26/20 191... (Address) 211 W. Wildkey Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rodef Road
DATE OF BURIAL, 9/28, 1920

20-UNDERTAKER Jack Lewis
ADDRESS 1441 E Balto

19—B. P. Co.—1000 Bks.

6828 HEALTH DEPARTMENT—CITY OF BALTIMORE 64 No 046828

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

(a) BALTIMORE: (No. 2105 St. Paul St ST.: 12 WARD)

2. FULL NAME Josiah Booker Clift

3. RESIDENCE. NO. 2105 St. Paul ST., WARD.

(Usual place of abode) 37 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

(If nonresident give city or town and State)

(b) If of residence in city or town where death occurred [redacted] yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: Male White

5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed, or divorced (HUSBAND of (or) WIFE of): Husband.

6 DATE OF BIRTH (month, day, and year): May 8 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lawyer 042

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia, Lynchburg.

10 NAME OF FATHER: Josiah Clift Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norfolk Va

12 MAIDEN NAME OF MOTHER: Alice V. Booker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lynchburg Va

14 Informant (Address): Walter C. Bacon 100 E 20th St

15 SEP 26 1920 ROBERT I. LIGHTER Registrar

Bur. of Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 24 1920.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1918. to Sept 23 1920.

that I last saw him alive on Sept 23 1920,

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ½ hr

CONTRIBUTORY (Secondary): Chronic Endo Carditis

(duration) 2+ yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? B.P. 235

(Signed) Walter C. Bacon, M. D.

9/23/ 1920 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Sept 27 1920

20 UNDERTAKER: J. B. Cook — ADDRESS: 1003 N Balto St

19—H. P. Co.—1000 Bks.

6829 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046829

CERTIFICATE OF DEATH.

REGISTERED NO.

LACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

F BALTIMORE: (No.) New City Hospital ST.: 4 WARD)

ULL NAME Lizzie Wilson

RESIDENCE. No. 319 Park Ave ST., WARD. 10

(Usual place of abode) (If nonresident give city or town and State)

h of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
ale	White	Unknown

married, widowed, or divorced HUSBAND of (or) WIFE of Widow

TE OF BIRTH (month, day, and 1888

E Years	Months	Days	If LESS than 1 day, hrs. or min.
32	7	14	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Nashville, Tenn.

10 NAME OF FATHER John Eppin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 SEP 26 1920 ROBERT B. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1920, to Sept. 24, 1920.

that I last saw h... er alive on September 24, 1920.

and that death occurred, on the date stated above, at 11:50 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the uterus.

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of ?

Was there an autopsy? No.

What test confirmed diagnosis? No especial test

(Signed) J. H. Ernman, M. D.

9/24/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Sept 27 1920
20 UNDERTAKER	ADDRESS
John J. Falls	1200 W. Fayette

24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46830 4P 046830

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

OF BALTIMORE: (No. 2232 Harford Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME George W. Horn

ence in Baltimore: No. 2232 Harford Ave St.; 50 yrs., mos. ds.)

ERSONAL AND STATISTICAL PARTICULARS.

	4-COLOR OR RACE,	5- MARRIED, (Write the word.)
ale	White	Married

S OF BIRTH, Aug. 22, 1870
(Month) (Day) (Year)

E, If LESS than 1 day, hrs. or min.?

7 yrs. 1 mos. 1 ds.

CUPATION:
) Trade, profession, or particular kind of work: Retired 013
) General nature of industry, business, or establishment in which employed (or employer): Brother

IRTHPLACE, State or Country), Germany

10-NAME OF FATHER, George L Horn

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Metz

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin Horn

(Address) 2232 Harford Ave

15-

Filed SEP 26 1920, 191... ROBERT F KRAUTER Registrar

Burial Permit ...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 23, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 6 1920, to Sept 23 1920, that I saw h... alive on Sept 22 1920, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. C. Heaver M. D.

9/25, 192.. (Address) 1660 E Biddle St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Farmer or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem

DATE OF BURIAL, 9/27, 1920

20-UNDERTAKER George J. Rutt

ADDRESS 1735 Harford Ave

19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

6831 — CERTIFICATE OF DEATH. — 152 — 1046831

PLACE OF DEATH

OF BALTIMORE: (No. 275 N. Exeter ST.; 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Enrico Castro

RESIDENCE. No. 275 N. Exeter ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life mos ds

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
ale	White	Single

married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Sept. 16-192

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — old

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Mariano Castro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Guiseppa Russo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Giuseppa Castro

(Address) 275 N. Exeter St.

15 Filed SEP 26 1920 19 ROBERT E. LEAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1920, to Sept. 25, 1920, that I last saw him alive on Sept. 25, 1920, and that death occurred, on the date stated above, at 11. P. m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) umbilical infection

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. Palmisano, M. D.

, 19 (Address) 75 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincent Cem.	9/27 1920
20 UNDERTAKER	ADDRESS
George J. Puth	1735 Hanford Ave

24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

6832

CERTIFICATE OF DEATH.

15 REGISTERED NO. C 46832

PLACE OF DEATH

OF BALTIMORE: (No. 3140 Elmora Av. ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Baby Bass

dence in Baltimore: No. 3140 Elmora Av. St.; ..... yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
ale	White	Single

TE OF BIRTH, Sept 24, 1920
(Month) (Day) (Year)

GE,	If LESS than 1 day,
..... yrs. ..... mos. 1 ds.	....hrs. or.....min.?

CCUPATION:
) Trade, profession, or particular kind of work ..... None
) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE, State or Country), Md.

10-NAME OF FATHER, Henry W Bass

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Rubetta Esley

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Bass

(Address) 3140 Elmora Ave

15- SEP 27 1920 Filed ....., 191... ROBERT J KRAUTER Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 25, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1920, to Sept 25 1920, that I saw him alive on Sept 25 1920, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jacob Fisher M. D.

Sept 26, 1920 (Address) 1823 N Wash St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltolawn — DATE OF BURIAL, Sept 27th, 1920.

20-UNDERTAKER Leo D. Cook — ADDRESS North & Milford Ave.

46833 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046833.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. Royster Guano Company Fairfield. ST. 22 181 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Caldwell (C)

Residence in Baltimore: No. 338 Dover St. (28 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, Colored.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married.

6-DATE OF BIRTH, Do not know. (Month), 1 (Day), ... (Year)

7-AGE, 62 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer in 040
(b) General nature of industry, business, or establishment in which employed (or employer): Guano factory.

9-BIRTHPLACE, (State or Country), South Carolina.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mabel Caldwell (C) wife.

(Address) 932 N. Futaw St.

SEP 27 1920 ROBERT B BRAUER

Filed....., 191..... Burial Permit (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 23rd. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Electrocution.
Accidentally coming in contact with
from electric wire.
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M Reinhardt M. D.
(Coroner.)

Sep. 24., 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Ct	Sept 27, 1920
20-UNDERTAKER	**ADDRESS**
L. H. Brandt & Son	1611 N. Montgomery

19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~4834~~ 28 L 046834

PLACE OF DEATH

OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 3 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Nathan Thomas

RESIDENCE. No. 115 S. Dallas St. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
~~Male~~	Colored	Married

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mattie Thomas

DATE OF BIRTH (month, day, and year) 1897

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of indostry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

BIRTHPLACE (city or town) (State or country): Florida

PARENTS

10 NAME OF FATHER: Frank Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Georgia

12 MAIDEN NAME OF MOTHER: Laura Mays

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Georgia

14 Informant: Hospital Records
(Address) M.T.H. ~~BOULEVARD & FLUTES~~

15 FILED SEP 27 1920 Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1920, to Sept. 22, 1920, that I last saw him alive on Sept. 21, 1920, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous broncho-pneumonia. (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) L. J. Rigney, M. D.

9-24-20. 19 (Address) Municipal Tuberculosis Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	Sept 24 1920
20 UNDERTAKER John W. Henderson	ADDRESS 1502 Monument

9-19—H. P. Co.—1000 Bks.

6835 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 50 — 046835

CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE: (No. 3429 Edmonson Ave ST.: 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Hamilton C Merryman

(a) RESIDENCE. No. 3429 Edmonson Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ~~60~~ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L Merryman

DATE OF BIRTH (month, day, and year) July 4 1855

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	2	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) O/S

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Abner Merryman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Carlisle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary L. Merryman
(Address) 3429 Edmonson Ave

15 DATE RECEIVED SEP 27 1920 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1920

17 I HEREBY CERTIFY, That I attended deceased from July, 1918, to Sept 24, 1920, that I last saw him alive on Sept 24, 1920, and that death occurred, on the date stated above, at 5-50 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank H. Hillis, M. D.

, 19 (Address) 3838 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvert	Sept 27 1920
20 UNDERTAKER W J Lickner & Son	ADDRESS Bath St

19—H. P. Co.—1000 Blks.

6836 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046836

CERTIFICATE OF DEATH. 104

REGISTERED NO.....

PLACE OF DEATH

OF BALTIMORE: (No. 1341 Richardson ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Elenora E Johnson

RESIDENCE. No. 1341 Richardson ST. 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE: Female White

5 Single, Married, Widowed, or Divorced (write the word): Single

If married, widowed, or divorced: HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year): Jan 24-20

AGE: Years 8 Months 9 Days If LESS than 1 day: hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: M J Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Thelma Mausch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: M J Johnson (Address) 1341 Richardson

15 Filed SEP 27 1920 ROBERT F KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 24 1920

17 I HEREBY CERTIFY, that I attended deceased from June, 1920 to Sept 24, 1920

that I last saw her alive on Sept 23 1920 8 45 P.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M J Johnson M. D.

, 19 (Address) 1320 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Sept 27 1920

20 UNDERTAKER: J. J. Gray & Son — ADDRESS: 1318 Light

46837 HEALTH DEPARTMENT—CITY OF BALTIMORE D 46837

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2608 E. Fayette ST.. 6 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Zeltzer.

Residence in Baltimore: No. 2608 E. Fayette St.; yrs., 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, June (Month) 7 (Day), 1842 (Year)

7-AGE, 78 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At home
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Paul

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Anna Zeltzer

(Address) 2608 E Fayette

15-SEP 27 1920 ROBERT B KRAUTER

Filed....., 191..... Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH 9/25, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 8 hrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) G. Glades M. D. (Coroner)

9/25/20 191... (Address) 143 W Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Sept 28, 1920

20-UNDERTAKER J. J. Ben — ADDRESS 156 N. Eutaw

-19—H. P. Co.—1000 Bks.

6838 HEALTH DEPARTMENT—CITY OF BALTIMORE 046838

CERTIFICATE OF DEATH.

PLACE OF DEATH

OF BALTIMORE. (No.) 700 E. Glenwood Ave (St.) (Ward) 27

FULL NAME Frederick J. Hendricks

(Usual place of abode) RESIDENCE. No. 700 E. Glenwood Ave St. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? 57 yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara Hendricks

DATE OF BIRTH (month, day, and year): April 29-1843

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	4	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Dont Know.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Lillie M. Stueber.

(Address) 700 E. Glenwood Ave

15 Filed SEP 27 1920 ROBERT F. LEAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 25 1920

17 I HEREBY CERTIFY, That I attended deceased from September 21 1920 to September 25 1920.

that I last saw h[im] alive on Sept 20 1920.

And that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination & Percussion

(Signed) G. W. Bishop M. D.

19 (Address) 801 Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Sept 27th, 1920

20 UNDERTAKER: Wm & Jno H. Teufel ADDRESS: 801 W. Fayette St.

19-K. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4839 — #146839

REGISTERED NO.....

PLACE OF DEATH

OF BALTIMORE: (No. 609 W. West ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Fred John Rixse

RESIDENCE. NO. 609 W. West ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

If married, widowed, or divorced WIFE of (or) HUSBAND of: Flora E. Rixse

DATE OF BIRTH (month, day, and year): Aug 24, 1859

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	1	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Glass Blower

(b) General nature of industry, business, or establishment in which employed (or employer): Lowndells 086

(c) Name of employer

BIRTHPLACE (city or town) (State or country): N. Y.

PARENTS

10 NAME OF FATHER: John Rixse

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Flora E Rixse 609 W. West St.

15 Filed SEP 27 1920 ROBERT E KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 26 1920.

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1920, to Sept. 26, 1920., that I last saw him alive on Sept. 25, 1920. and that death occurred, on the date stated above, at 2. A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Naso-Pharynx

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Dellett, M. D.

Sept. 26, 1920 (Address) 621 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Sept 29 1920

20 UNDERTAKER: Mr. Mrs John W. Teufel — ADDRESS: 50 W. Fayette

9-19—H. P. Co.—1000 Bks.

6840 HEALTH DEPARTMENT—CITY OF BALTIMORE 1946840

CERTIFICATE OF DEATH. 28

PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (NO. 842 Mangold ST.: 21 WARD)

FULL NAME Theodore R Remmey Jr

(a) RESIDENCE. NO. 842 Mangold ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

gth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) April 25 1891

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
29	4	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Drug Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Theo. R. Remmey

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Buchheit

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Theodore R Remmey
(Address) 842 Mangold St

15 SEP 27 1920 ROBERT I LAUTER Registrar
Burial Permit Oliet

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1920

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1920, to Sept. 23, 1920, that I last saw him alive on Sept 22, 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Mitral Regurgitation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilitation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Edw. Archer, M. D.

, 19 (Address) 1430 Riverside Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL BALTIMORE CEMETARY

DATE OF BURIAL SEP 27 1920

20 UNDERTAKER JOHN F. DENNY

ADDRESS 715 LIGHT ST.

46841 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46841

CERTIFICATE OF DEATH. 169

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) Pier 2- Patt St. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rufus F. Menters.

Residence in Baltimore: No. 736 Penna Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1894 (Year)

7-AGE, 26 yrs. mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 040
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

9-BIRTHPLACE, (State or Country), Penn

PARENTS.

10-NAME OF FATHER, George Menters

11-BIRTHPLACE OF FATHER (State or Country), Penn

12-MAIDEN NAME OF MOTHER Foster

13-BIRTHPLACE OF MOTHER (State or Country), Penn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian Menters

(Address) 736 Penn Ave

15- SEP 27 1920 ROBERT B. RUTER

Filed ....., 191.... Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9/24, 1914
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Accident) Drowning

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. A. Blake M. D.
(Coroner.)

9/26/14 (Address) 1437 E. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Auburn Cemetery — DATE OF BURIAL, Sept 27 1920

20-UNDERTAKER John H. Todd — ADDRESS 2411 Hill St

S-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46842 — 79 — S46842

CERTIFICATE OF DEATH.

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
OF BALTIMORE: (No. 823 N. Eutaw St. ST.; 11 WARD)

2-FULL NAME Mary C. Beasley

Residence in Baltimore: No. 823 N. Eutaw St. St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH, May (Month) 12 (Day), 1840 (Year).

7-AGE, 80 yrs. 4 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Ohio

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Alice Beasley

(Address) 823 N. Eutaw St.

15- FILED SEP 27 1920, 191.... ROBERT F. LEUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 24th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from (called at 11.30 & found her dead at 12 P.M.) 191.., to 191.., that I saw her alive on Sept 24th 1920, and that death occurred, on the date stated above, at 12 P. m. (Midnight)

The CAUSE OF DEATH* was as follows: Myocarditis (Coronary arterio-sclerosis)

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Indigestion (nausea and vomiting) about 2 hrs.

(Duration) ....yrs....mos....ds.

(Signed) Wm. F. Lockwood M. D.

Sept 25th, 1920 (Address) 8 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Thomas Garrison Forest Md — DATE OF BURIAL, Sept 27, 1920

20-UNDERTAKER Chas. E. Mauck — ADDRESS 807 Madison

6843

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046843.

105

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: No 519 S. Fourteenth ST.: 26 WARD)

FULL NAME Maria C. Connell.

) RESIDENCE. NO. 519 S. 14th ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

th of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White.	Single

married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Aug 11-1914

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	1	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James F. Connell.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pittsburgh Pa.

12 MAIDEN NAME OF MOTHER Frances Sauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) James F. Connell. 519 S. 14th St.

15 FILED SEP 27 1920 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 1920

17 I HEREBY CERTIFY, That I attended deceased from 9/24/20. 19 . to 9/24/20. 19 .
that I last saw h[illegible] alive on 9/24/20 19 .
and that death occurred, on the date stated above, at 4.05 A. m.
The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none.

(Signed) F. W Herrmann M. D.
9/26 1920 (Address) 2919 E Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Sept. 28 1920.
20 UNDERTAKER Lilly and Zeiler.	ADDRESS 403 S. Wolfe St.

8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1844

CERTIFICATE OF DEATH.

REGISTERED NO. C 79 / 0468 44

PLACE OF DEATH Little Sisters of the Poor

OF BALTIMORE: (NO. ..... ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Margaret Hotten

dence in Baltimore: No. Little Sisters of the Poor St.; 50 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
X. Female	White	Wid

TE OF BIRTH, May (Month) 20 (Day), 1848 (Year)

GE, 72 yrs. 4 mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.?

CCUPATION:
a) Trade, profession, or particular kind of work ..... None 000
b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE, (State or Country), Pennsylvania ~~Unk~~

10-NAME OF FATHER, Philipp Wayman

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Catherine Wayman

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Benedict

(Address) Little Sisters of the Poor

15- SEP 27 1920 191.....

~~OL~~ Burial Permit Received.

MONEY & EFFECTS

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 25, (Day) 1920 (Year) D

17- I HEREBY CERTIFY, That I attended deceased from May 1920, to ..... 191....., that I saw h er alive on Sept 25 1920, and that death occurred, on the date stated above, at 5.15 p.m.

The CAUSE OF DEATH* was as follows:

Val Disease of heart

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dropsy

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. A. Warner M. D.

Sept 25, 1920 (Address) 1133 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State 50 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	Sept 28, 1920
20-UNDERTAKER H. C. Wadefield	ADDRESS 1st Greenmount Ave

6-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46845

CERTIFICATE OF DEATH.

REGISTERED NO. C 172

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
(a) OF BALTIMORE: (No. 416 N Kenwood ave ST.: 6 WARD)
(b) NOT IN BALTIMORE: (City or County)

2-FULL NAME Charlet V Simms (If not known, supply information required as to deceased.)

Residence in Baltimore: No. 416 N Kenwood ave St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Jan 6 (Month) (Day) 1919 (Year)

7-AGE, 1 yrs. 2 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work ..... (b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

10-NAME OF FATHER, Samuel J Simms

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Lassie Duncan

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel J Simms

(Address) 416 N Kenwood ave

15- Filed SEP 27 1920 ROBERT B ARMSTRONG Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 25 (Month) (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 19 1920, to Sept 25 1920, that I saw h[illegible] alive on Sept 25 1920, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular

Duration 6 ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Esther G Hirsch M. D.

9/26, 1920. (Address) 1600 E Balt St.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery DATE OF BURIAL, Sept 27, 1920.

20-UNDERTAKER Mrs. C. Miller ADDRESS 2334 Jefferson st

1-9-19—H. P. Co.—1000 Blks.

246846 HEALTH DEPARTMENT—CITY OF BALTIMORE D46846

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1. PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (No.) St. Agnes' Hospital ST. 21 WARD)

2. FULL NAME Mr. John S. Gunder

3. (a) RESIDENCE. NO. 1561 Ridgley St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

4 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of deceased

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE Years 64 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED 031

(a) Trade, profession or particular kind of work notary queen

(b) General nature of industry, business, or establishment in which employed (or employer) Machinist

(c) Name of employer Pool & Hunt.

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) England " "

12 MAIDEN NAME OF MOTHER " " " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant George Gunder (Address) 1561 Ridgley St

15 Filed SEP 27 1920, 19 ROBERT E. L. Registrar

Burial Permit Clerk

16 DATE OF DEATH (month, day, and year) Sept 25 1920

17 I HEREBY CERTIFY, That I attended deceased from 9-25, 1920, to 9-25, 1920, that I last saw him alive on 9-25, 1920, and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of the Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio Renal Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) W. M. Craig, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Sept 28 1920

20 UNDERTAKER Wastler Fahey & Sons

ADDRESS 1827 N North Av

46847

D 46847

1-9-19—H. P. Co.—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. 15 E. Centre ST.: 11 WARD)

1. FULL NAME Annie Fralinger

(a) RESIDENCE. No. 15 E Centre ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

2 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Florey Fralinger

6 DATE OF BIRTH (month, day, and year): 1868

7 AGE: Years 52; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 037

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Mc. Keown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Florey Fralinger

(Address): 15 E Centre St

15 Filed SEP 27 1920 19 Burial Permit Clerk
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 17th, 1920, to Sept 26th, 1920.

That I last saw h[illegible] alive on Sept 24th, 1920.

and that death occurred, on the date stated above, at 11.50 A. m.

The CAUSE OF DEATH* was as follows:

Valv Dis of Heart
(Initial)

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Hypostasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E Gamble, M. D.

19 (Address) 607 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Sep 28 1920

20 UNDERTAKER: F. A. Krause & Son

ADDRESS: 703 Hanover

9-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6848 REGISTERED NO. C 64 D 4 8 4 5

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

OF BALTIMORE: (No. 1117 Lorain Ref. Balto. St.; 28 WARD)

2-FULL NAME Mrs. Mary A. Foley

idence in Baltimore: No. Washington D. C. St.; yrs., 2 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

X. Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Widow

TE OF BIRTH, March 10, 1845 (Month) (Day) (Year)

If LESS than 1 day, ...hrs. or...min.?

GE, 75 yrs. 6 mos. ds.

CCUPATION: a) Trade, profession, or particular kind of work Retired Good

b) General nature of industry, business, or establishment in which employed (or employer) Home Duties

IRTHPLACE, State or Country), Ireland

10-NAME OF FATHER, Hugh Mc. Donald

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Bridget Biggins

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Friend of Mrs. Foley Retired

(Address) Balto. Md.

15- Filed SEP 27 1926, 191... ROBERT E KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 26, 1926 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15 1926, to Sept 26 1926, that I saw h dr alive on Sept 26 1926, and that death occurred, on the date stated above, at 10. P. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Senile Dementia

(Duration) Life yrs. mos. ds.

(Signed) C. Chandler G. H. Hyde M. D.

Sept 27, 1926. (Address) 1st. Hyde Natnl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 11 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Washington D C

Former or usual residence Washington D C

19-PLACE OF BURIAL OR REMOVAL, Washington D.C. DATE OF BURIAL, Sept 27, 191...

UNDERTAKER STEUART & OWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

Burial Permit

46849 HEALTH DEPARTMENT—CITY OF BALTIMORE D 46849

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1224 Oleans St. 5 Ward) REGISTERED No. C 104

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Wise

Residence in Baltimore, No. 1224 Oleans St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Femal

4-COLOR OR RACE: Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Single

6-DATE OF BIRTH: June (Month) 27 (Day), 1919 (Year)

7-AGE: 1 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Dalto Talk. Md

PARENTS.

10-NAME OF FATHER: David Wise

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Hattie Queen

13-BIRTHPLACE OF MOTHER (State or Country): md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Queen

(Address) 1224 Oleans St

15-
DEC SEP 27 1920 191 ROBERT J. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

THE CAUSE OF DEATH* was as follows:

(a) Gastro Enteritis

(b) (Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 1 ds.

(Signed) C. E. Blake M. D.
(Coroner.)

9/27/20, 191.. (Address) 1437 E Fay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Laurel Conn

DATE OF BURIAL: Sept 27, 1920

20-UNDERTAKER: Daniel Easton

ADDRESS 716 Eutaw

9-19—H. P. Co.—1000 Blks.

46850

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46850

CERTIFICATE OF DEATH.

4 1

PLACE OF DEATH

OF BALTIMORE: (No.) 756 Sarah Ann (St.:) (Ward) 4

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Wm. Green

(a) RESIDENCE. No. 756 Sarah Ann ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 6 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed, or divorced, HUSBAND of (or) WIFE of: Blanche Green

DATE OF BIRTH (month, day, and year): Mch 1-1891

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29 -	6 -	26	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Jas. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Annie Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Alice Boulden 702 Druid Ave

15 SEP 27 1920 ROBERT B. EMMUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1920, to Sept 26, 1920, that I last saw h[illegible] alive on Sept 26, 1920, and that death occurred, un the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever 7

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Gr Regular

(Signed) F G Lasky M. D.

Sept 27 (Address) 1313 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 29 1920
20 UNDERTAKER	ADDRESS
Daniel Easton	916 Pine

9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46851 91 D 46851

REGISTERED NO.

PLACE OF DEATH Bay View Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (No.) ST.: 26 WARD)

FULL NAME Leni Blaut

(a) RESIDENCE. NO. 3601 E. Pratt. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

If married, widowed, or divorced, HUSBAND of (or) WIFE of unknown

DATE OF BIRTH (month, day, and year) 1843

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) 088

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

16 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant Bay View Hospital (Address) Balto City.

15 FILED SEP 27 1920 ROBERT B. KLAUER Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1919 to Sept. 25, 1920.

that I last saw him alive on Sept. 25, 1920 and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (terminal) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis Brain Disease (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) A. Goldsmith M. D.

9/27/20 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	9/28 1920

20 UNDERTAKER H. Wm. Goodheim ADDRESS 1107 Wood

9-19—H. P. Co.—1000 Blks.

46852 HEALTH DEPARTMENT—CITY OF BALTIMORE 154 246852

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (No. 2306 Madison Ave 13 WARD)

FULL NAME Regina Mansbach

(a) RESIDENCE. No. 2306 Madison Ave WARD.

(Usual place of abode)

(Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of widowed

6 DATE OF BIRTH (month, day, and year) 1847

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73 yrs			

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) Germany.

(State or country)

PARENTS

10 NAME OF FATHER Mansbach

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Germany.

(State or country)

14 Informant Dan. Mansbach

(Address) 2306 madison ave

SEP 27 1920 ROBERT P. LEUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 8th, 1920, to Sept 27th, 1920, that I last saw h... alive on Sept 27th, 1920, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Samuel Wentzy, M. D.

, 19 (Address) 2302 Madison Ave.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Balt Hebrew Sep 29 1920

ADDRESS

20 UNDERTAKER

Landsman 1118 N. Eutaw

446853 HEALTH DEPARTMENT—CITY OF BALTIMORE V 446853

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3oot of Bayard St. ST. 21 WARD) 169 REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Williams.(C)

Residence in Baltimore: No. 1109 Russell St. (St.; 11 yrs., 0 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single.

6-DATE OF BIRTH, September 9th. 1909, 1 (Month) (Day) (Year)

7-AGE, 11 yrs. 0 mos. 16 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None. 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER, James Mobray.(C)

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Annie Williams.(C)

13-BIRTHPLACE OF MOTHER (State or Country), Cambridge, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Williams.(C)mother.

(Address) 1109 Russell St.

15- SEP 27 1920 Filed, 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 25th. 1920, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidentally drowned while in swimming. (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) ...(Duration) ...yrs. ...mos. ...ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

Sep 26 20, 191... (Address) 1517 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, 9-28, 19 20

20-UNDERTAKER Sam'l H. Cage Sons — ADDRESS 400 Mosher

8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46854

46854

CERTIFICATE OF DEATH.

14

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 339 N. Bruce ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Estell Nelson

Residence in Baltimore: No. 339 N. Bruce ave St.; 3 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April 17, 1886
(Month) (Day) (Year)

7-AGE, 34 yrs. 5 mos. 9 da.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Keeping
(b) General nature of industry, business, or establishment in which employed (or employer)..... 37

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Edmund Roberson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Fannie Spurlock

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... H. Wilson

(Address) 339 N. Bruce

15- Filed SEP 27 1920, 191.... ROBERT B. KRAUTH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 26, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/12 1920, to 9/26 1920, that I saw her alive on Sept 25 1920, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows: Anaemia Dysentery

..... (Duration) ..... yrs. 1 mos. ..... da.

CONTRIBUTORY (Secondary) Intestinal Perforation

Peritonitis (Duration) ..... yrs. ..... mos. 2 da.

(Signed) H. Hays M. D.

9/27, 1920 (Address) 613 N. Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, West Lomb Va

DATE OF BURIAL, 9-27, 1920

20-UNDERTAKER Sam'l H. Chase Son

ADDRESS 1400 N. Mich

6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46855 D46855

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

1-PLACE OF DEATH

Y OF BALTIMORE: (No. 1709 Jackson ST.: 24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carroll Ellsworth Bezjat.

(a) RESIDENCE. No. 1709 Jackson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 10 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Infant.

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

7 DATE OF BIRTH (month, day, and year) Nov. 4 1916

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	10	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant 000
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Ellsworth Bezjat.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Florence Samson 920

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Ellsworth Bezjat.
(Address) 1709 Jackson St.

15 Filed SEP 27 1920 19 BURKEY S. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/25 1920

17 I HEREBY CERTIFY, That I attended deceased from 9/25/20, 19..., to 9/25/20, 19..., that I last saw h.. alive on 9/25/20, 19..., and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows: OVER

Bronchio Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) P. Lilio B. Lowter, M. D.

(Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Sept. 27 1920

20 UNDERTAKER: E. J. Fanning & Son — ADDRESS: 1410 Bathey Ave.

6-9-19—H. P. Co.—1000 Bks.

Ettwein Manuel. V D46856

HEALTH DEPARTMENT—CITY OF BALTIMORE

46856

CERTIFICATE OF DEATH.

119

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 832 Greenmount Ave ST. 10 WARD)

2-FULL NAME Louise Manuel

(a) RESIDENCE. No. 832 Greenmount Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F M	Col. Aa	Married

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

7 DATE OF BIRTH (month, day, and year) 1876

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Trenton N J.

PARENTS

10 NAME OF FATHER John H Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) M. d.

12 MAIDEN NAME OF MOTHER Annie James

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant John Manuel

(Address) 832 Greenmount ave

15 Filed SEP 27 1920 19 ROBERT I. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/24 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 8th, 1920, to Sept 24, 1920, that I last saw her alive on Sept 24th, 1920, and that death occurred, on the date stated above, at 1.20 p m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis and Gastritis

(duration) 2 yrs. 2 mos. 20 ds.

CONTRIBUTORY (Secondary) Cirr and Kidney Trouble with Dropsy (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Geo L Hall, M. D.

, 19 (Address) 1426 E 23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt auburn Cemetery	Sept 27 1920

20 UNDERTAKER R & Gross ADDRESS 1405 McElderry

Over

9-19—H. P. Co.—1000 Blks.

345-9
6857

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 046857

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

OF BALTIMORE: (NO. Johns Hopkins Hospital ST.: E WARD)

FULL NAME Vincenta Czepulis

) RESIDENCE. NO. 312 S. Bank St. Baltimore Md ST.: WARD.
(Usual place of abode)

(If nonresident give city or town and State)

th of residence in city or town where death occurred yrs. mos. 7th ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
ale	White	Single

married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) July 16 - 1920

GE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Kostanty Czepulis.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Annie Alepius

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant 312 H.
(Address)

15 Filed SEP 27 1920 ROBERT I. KLAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1920, to Sept 26, 1920, that I last saw h. alive on Sept 26, 1920, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhea
(not Dysentery)

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. D. Lawson, M. D.

, 19 (Address) 312 H. Bank Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent Cemetery — DATE OF BURIAL: Sept 27 1920

20 UNDERTAKER: George J. Ruth — ADDRESS: 1735 Harford Ave

5-19-13—M. & T.—500 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

6858

CERTIFICATE OF DEATH.

151 D46858

REGISTERED NO. C .....

1-PLACE OF DEATH

OF BALTIMORE: (No. 844 Reinhardt ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Wolf.

idence in Baltimore: No. 844 Reinhardt St.; ...yrs., mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

ATE OF BIRTH,. Sept 13, 1920
(Month) (Day) (Year)

AGE. ...yrs. ...mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

OCCUPATION:
(a) Trade, profession, or particular kind of work..... None 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Frank A Wolf

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Agnes Clark

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank A Wolf

(Address) 844 Reinhardt

15- SEP 27 1920. 191. ROBERT J. BRUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 27, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1920, to Sept 27 1920, that I saw h- alive on Sept 26 1920, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

.....

.....Pneumonia Both

..... (Duration) ...yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary) Diabetes Cont

..... (Duration) ...yrs. 2 mos. 6 ds.

(Signed) E Dwight Crouch M. D.

9/27, 1920. (Address) 517 Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem

DATE OF BURIAL, Sept 27, 1920

20-UNDERTAKER W M Rountree

ADDRESS 230 N Greene

D. 46859

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 545 N. Pressman ST. 14 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph C. Crawley

(Residence in Baltimore: No. 545 N. Pressman St.; yrs.. mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, September 10, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 14 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): (In home)

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Mack Crowley

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Eleanor Talbert

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. McCrowley

(Address) 545 N Pressman St.

15- Filed SEP 7 1920, 191.... Registrar.

Robert P. Harrison, M.D.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 7, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) and Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Dated Sept 7 1920 (Address) 250 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, SEP [illegible] 1920

20-UNDERTAKER

ADDRESS

6-9-19—H. P. Co.—1000 Bks.

20.46860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

1—PLACE OF DEATH

OF BALTIMORE: (No. New City Hospital ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Clarke

(a) RESIDENCE. No. 115 W. Saratoga St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Unknown

If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
At last birthday	Unknown			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records.
(Address) New City Hospital

15 Filed SEP 27 1920 Robert P. Harrison,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24, 1920

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1920, to September 24 1920, that I last saw her alive on September 23, 1920, and that death occurred, on the date stated above, at 5:40 A. m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test.

(Signed) B Sherman M. D.

9/24/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	SEP 1920
20 UNDERTAKER Health. WOODALL	ADDRESS

UNIVERSITY OF MARYLAND

46861 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46861

CERTIFICATE OF DEATH. 155

REGISTERED NO. C

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. 2622 Huntingdon Av. ST.; 17 WARD)

2-FULL NAME Pauline Brocato (If not over 1 year, St.; yrs., mos. ds.)

Residence in Baltimore: No. 2622 Huntingdon Av.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write word): Married

6-DATE OF BIRTH, Feb. 2, (Month) (Day) 1903 (Year)

7-AGE, 17 yrs. 7 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Italy

PARENTS.

10-NAME OF FATHER: Antonio Catanese

11-BIRTHPLACE OF FATHER (State or Country): Italy

12-MAIDEN NAME OF MOTHER: Gertrude ?

13-BIRTHPLACE OF MOTHER (State or Country): Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Brocato

(Address) 2622 Huntingdon Ave.

15- Filed SEP 27 1920, 191..... Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9/26, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide Carbolic Acid

(Duration) yrs. mos. 2 ds.

Shock.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. 1 hr ds.

(Signed) G. C. Gladu M. D.

9/26/20 (Coroner) (Address) 1437 E. Bway

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mobile, Alabama DATE OF BURIAL, Sept 27, 1920

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 W Balto St

8-24-14—M. & T.—2000 Bks.

6862 HEALTH DEPARTMENT—CITY OF BALTIMORE 10,46862

CERTIFICATE OF DEATH.

109

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A. Kelly Hospital St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Elizabeth Spalding

Residence in Baltimore: No. 1418 Eutaw Place St.; ....yrs.,....mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, ? (Month) ? (Day) 1806 (Year)

7-AGE, 64 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Grove Hill Alabama

PARENTS.

10-NAME OF FATHER, James A. Spalding

11-BIRTHPLACE OF FATHER (State or Country), South Carolina

12-MAIDEN NAME OF MOTHER Amada Jo Gilbert

13-BIRTHPLACE OF MOTHER (State or Country), South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Albert Spalding

(Address) Wisemont Ave.

15- Filed Sept 27 1920, Robert P. Harrison, 191..... Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September (Month) 27 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 8 1920, to Sept 27 1920, that I saw her alive on Sept. 27 1920, and that death occurred, on the date stated above, at 3:12 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Robert E. Tucker M. D.

Sept. 27, 1920 (Address) Howard A. Kelly Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 19 ds. In the State ....yrs. ....mos. 19 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 2100 1st Ave. S. Birmingham Ala.

19-PLACE OF BURIAL OR REMOVAL, Forest Park Cemetery DATE OF BURIAL, Sept. 28, 1920

20-UNDERTAKER Chas. G. Black ADDRESS 742 Northaven

46863 Krystkiewicz D. 46863

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1V

1-PLACE OF DEATH
CITY OF BALTIMORE (No. St Agnes Hospital ST.; 3 WARD)
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislaus Krystkiewicz
Residence in Baltimore: No. 6245 Bond St.; yrs., 39 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mal
4-COLOR OR RACE, white
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Mar 25, 1881
(Month) (Day) (Year)

7-AGE, 61 yrs. 6 mos. ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Nom
(b) General nature of industry, business, or establishment in which employed (or employer)..... 800

9-BIRTHPLACE, (State or Country), Poland

PARENTS.
10-NAME OF FATHER, Stanislaus Krystkiewicz
11-BIRTHPLACE OF FATHER (State or Country). Poland
12-MAIDEN NAME OF MOTHER Rozalia X ?
13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alexandra Krystkiewicz
(Address) 716 S Bond St

15-
Filed SEP 27 1920, 191.....
Robert P. Harrison,
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 26, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.
The CAUSE OF DEATH* was as follows:
Bullet Shot Wounds - Chest Back Penetrating Abdomen Causing Peritonitis
(Duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Internal Hemorrhage
(Duration) yrs. mos. 20 ds.
(Signed) James W Fink M. D.
(Coroner.)
Sept 27 1920 (Address) 700 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENCE).
At place of death.....yrs.....mos. 3 ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence. 2645 Bond St

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Sept 29, 1920

20-UNDERTAKER, John H Weber — ADDRESS 1803 Bank St

6-9-19—H. P. Co.—1000 Bks.

46864 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046864

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

OF BALTIMORE: (No. 925 S. Sharp ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Gray

(a) RESIDENCE. NO. 925 S. Sharp ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred all life yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Sin.

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) Apr. 23, 1920.

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Clarence Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A. Ellis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mother Mary Gray
(Address) 925 S Sharp St

15 Filed SEP 28 1920 LOUIS B [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/27 1920

17 I HEREBY CERTIFY, That I attended deceased from 9/7, 1920, to 9/27, 1920, that I last saw him alive on 9/26, 1920, and that death occurred, on the date stated above, at 7.10 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculus Cerebro-Spinal Meningitis
(durntion) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. H. Curvee, M. D.

9/27 1920 (Address) 140 W. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. M. Cathedral Cem	9/28/20

20 UNDERTAKER R. A. Elliott ADDRESS 1115 Pulaski

5-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-46865

46865

CERTIFICATE OF DEATH.

1152

REGISTERED NO.

1. PLACE OF DEATH
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (No. City Hospital, Bay View WARD)

2. FULL NAME Annie Fields.

(a) RESIDENCE. No. 208 N. Dunham ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black.	Widowed.

If married, widowed, or divorced HUSBAND of (or) WIFE of ?

DATE OF BIRTH (month, day, and year) 1866.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Records. (Address) City Hospital, Bay View

15 Filed SEP 28 1920 ROBERT B. LEAUTEY Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1920, to Sept. 25, 1920, that I last saw h.er alive on Sept. 25, 1920, and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic cholecystitis.

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Entero-colitis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) Volkerman, M. D.

, 19 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel cntry — DATE OF BURIAL Sept 28 1920

20 UNDERTAKER Mrs Bolt a Elliott ADDRESS 172 S- ashland av

Calloway.

046866 HEALTH DEPARTMENT—CITY OF BALTIMORE 79 046866

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 317. E. 21½ - St.: 17 - WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Calloway.

(Residence in Baltimore: No. 317. E. 21½ -24 St.: (yrs. 5 mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F | 4-COLOR OR RACE: C. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, Jan 15, 1883 (Month) (Day) (Year)

7-AGE, 37 yrs. 8 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): Dkl

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Frank Calloway

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Jane Adams

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Calloway

(Address) 317 E 21½ St

15- Filed SEP 28 1920 ROBERT J. REUTER Burial Permit (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 25, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) was and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Valvular Disease of Heart.

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) John Morrissey M. D. (Coroner)

1920 (Address) 3692 Roland Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel cmtry | DATE OF BURIAL, Sept 28 1920

20-UNDERTAKER Mc Baltzell | ADDRESS 1725 Ashland Av

—6-9-19—H. P. Co.—1000 Bks.

46867

HEALTH DEPARTMENT—CITY OF BALTIMORE

46867

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital St.; 17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eunice Jones

(a) RESIDENCE. No. 1144 Argyle Ave St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
50				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Crisfield Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Clifford Jones

(Address) 1144 Argyle Ave

SEP 28 1920

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 26, 1920, to Sept 27, 1920, that I last saw her alive on Sept. 27, 1920, and that death occurred, on the date stated above, at 6.20 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Myocardial Insufficiency

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Chron Interstitial Nephritis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) J. C. Murino, M. D.

9/27 1920 (Address) St Josephs Hos

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Sept 28 1920

20 UNDERTAKER: Samuel I Hemsley

ADDRESS: 578 N Bridge

CAUSE OF DEATH. ATTENTION is very important.

Burial Permit Clerk

6-9-19—H. P. Co.—1000 Bks.

6868 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046868

CERTIFICATE OF DEATH

1-PLACE OF DEATH Bay View Hospital 37

OF BALTIMORE: (No.) ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Pinkney

(a) RESIDENCE. No. 2214 Druid Hill Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Amanda Pinkney

DATE OF BIRTH (month, day, and year) 1875

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer): 089

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Pinkney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do.

12 MAIDEN NAME OF MOTHER: Sarah Pinkney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md Do.

14 Informant: Bay View Hospital
(Address)

15 SEP 28 1920 FOREST H. ELIOTT Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1920, to Sept 24, 1920, that I last saw him alive on Sept 24, 1920, and that death occurred, on the date stated above, at 2.50 P, m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the insane

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Luetic Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? By Serological Tests

(Signed) N. Fred Smith, M. D.

(Address) Bay View Hospital

9/28/1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Sept 28 1920
20 UNDERTAKER: Samuel F. Hemsley	ADDRESS: 578 N. Eden

—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16869 — 120 — 1046869

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 139 Pierce ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hester White

Residence in Baltimore: No. 939 Pierce St.; 37 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, Ge

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

DATE OF BIRTH, Unknown (Month) ..... (Day), 1870 (Year)

AGE, 50 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

OCCUPATION:
(a) Trade, profession, or particular kind of work, Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer) 041

BIRTHPLACE, (State or Country), Denton Md

PARENTS:
10-NAME OF FATHER, Thos White
11-BIRTHPLACE OF FATHER (State or Country) Denton Md
12-MAIDEN NAME OF MOTHER Stacie Clark
13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary Carter
(Address) 939 Pierce St

15- Filed SEP 28 1920, 191... Burial Permit Clerk ROBERT E KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 26 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 20 1920, to Sept 25 191..., that I saw her alive on Sept 25 1920 and that death occurred, on the date stated above, at 11.54 m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) H L Haddaway M. D.
9/27/20, 191... (Address) 117 N Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Sept 28, 1920

20-UNDERTAKER Samuel J Kennedy — ADDRESS 678 N Eutaw

1-9-19—H. P. Co.—1000 Bks.

6870

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

No 46870

120

REGISTERED NO.

PLACE OF DEATH

OF BALTIMORE: (No. 509 N. Hoffman ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Lucinda Dorsey

(a) RESIDENCE. No. 509 N. Hoffman ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1825

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
66		—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Lucaboles Co Md

PARENTS

10 NAME OF FATHER: Henry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Spruce Barkstey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Lewis R Dorsey 1836 Argyle Ave

15 Filed SEP 28 1920 ROBERT A KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1920, to Sept 25, 1920, that I last saw h[illegible] alive on Sept 25, 1920, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis

(Signed) [illegible], M. D.

[illegible] 19 (Address) 1118 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Sept 28 1920

20 UNDERTAKER: Samuel L Kennedy

ADDRESS: [illegible] Baltimore

46871 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046871

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2211 Wilkes St., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helena Tatlowski

Residence in Baltimore: No. 2211 Wilkes Court. (9 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, June (Month) 25 (Day), 1920 (Year)

7-AGE, ...yrs. 3 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... " "

9-BIRTHPLACE, (State or Country), Baltimore.

PARENTS.

10-NAME OF FATHER, Frank Tatlowski

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Antonina Jozylog

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Tatlowski

(Address) 2211 Wilkes Court

15-

Filed SEP 28 1920 ROBERT F. KEY Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 27 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Contusions

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Concussion

(Duration) yrs. mos. 1 ds.

(Signed) H. Colin Bladen M. D.

9/27/20, 1920 (Coroner.) (Address) 143 N. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary | DATE OF BURIAL, Sept 28 1920

20-UNDERTAKER Wm Hallowell | ADDRESS 168 East

T 1519

4-9-19—H. P. Co.—1000 Bks.

46872 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046872

CERTIFICATE OF DEATH.

40 v

1-PLACE OF DEATH

OF BALTIMORE: (No. St Janes Hospital St.: 8 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lena Fine

(a) RESIDENCE. No. 1102 Cutland Ave St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: W | 5 Single, Married, Widowed, or Divorced (write the word): M.

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mr M Fine

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	-	-	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant (Address) Mr M Fine 1102 Cutland Ave

15 Filed SEP 28 1920 ROBERT B. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 19 20

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 19 20, to Sept 27, 19 20,

that I last saw h.. alive on Sept 27, 19 20,

and that death occurred, on the date stated above, at 2 m. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Esophagus

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Haemorrhage Esophagus Ca

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) Geo A Stewart, M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Sinai Park	Sept 28 1920
20 UNDERTAKER	ADDRESS 1127 E
Max Levinson	Baltimore

046873

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

104 046873

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1420 Woodall St. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Doris Agnes Walker

(Residence in Baltimore: No. 1420 Woodall St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: June 18, 1920 (Month) (Day) (Year)

7 AGE: ..... yrs. 3 mos. 8 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Infant ooo
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Robert Walker

11 BIRTHPLACE OF FATHER (State or country): Ohio.

12 MAIDEN NAME OF MOTHER: Agnes Allen

13 BIRTHPLACE OF MOTHER (State or country): Balto Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Agnes Allen

(Address) 1420 Woodall St

15. Filed SEP 28 1920 ROBERT E KRAUTER Deputy Registrar REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. 26, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1920, to Sept. 26 1920, that I saw h[er] alive on Sept 26, 1920, and that death occurred, on the date stated above, at 6 30 a m. The CAUSE OF DEATH* was as follows:

Mo Colitis

(Duration) ..... yrs. ..... mos. 21 ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Trosta Stevens M. D.

Sept. 26, 1920 (Address) 2866 Leaford Rd,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Cedar Hill Cem

DATE OF BURIAL: Sept 28, 1920

20 UNDERTAKER: Margaret D. Flynn

ADDRESS: 1422 Light St.

046874 HEALTH DEPARTMENT--CITY OF BALTIMORE. 046874

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C 79

CITY OF BALTIMORE (No. 1738 Hull St. St. 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2 FULL NAME Joseph A. Cadden

(Residence in Baltimore: No. 1738 Hull St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH May 10, 1910 (Month) (Day) (Year)

7 AGE 10 yrs. 4 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Anthony P. Cadden

11 BIRTHPLACE OF FATHER (State or country) Balto Co Md.

12 MAIDEN NAME OF MOTHER Margaret V. Burns

13 BIRTHPLACE OF MOTHER (State or country) Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anthony P. Cadden

(Address) 1738 Hull St

15 Filed SEP 28 1920, 19 ROBERT B LEAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 27, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from apr. 27, 1920, to Sept. 27 1920 that I saw h[illegible] alive on Sept 26 1920 and that death occurred, on the date stated above, at 3a. m.

The CAUSE OF DEATH* was as follows:

Rheumatism

(Duration) yrs. 6 mos. — ds

Contributory (SECONDARY) Mitral Regurgitation

(Duration) yrs. 4 mos. — ds.

(Signed) Thos A Burns M. D.

Sept. 27, 1920 (Address) 2866 Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cathedral Cem. DATE OF BURIAL Sept. 30, 1920

20 UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light St.

6-9-19—H. P. Co.—1000 Bks.

46875

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D46875

120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

OF BALTIMORE: (No. New City Hospital ST.: 19 WARD)

2-FULL NAME Charles Green

(a) RESIDENCE. No. 1305 Mulberry St. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
ale	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 1859

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed SEP 28 1920 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27, 1920

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1920, to Sept. 27, 1920, that I last saw h. in alive on September 27, 1920, and that death occurred, on the date stated above, at 9:00 A. m.

The CAUSE OF DEATH* was as follows:

Arterio - sclerosis with cerebral thrombosis.

(duration) yrs. 9. mos. ds.

CONTRIBUTORY (Secondary) Chr. diffuse nephritis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed) W. B. Brannan M. D.

9/27/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	9/30/20

20 UNDERTAKER W. M. Cook ADDRESS 605 E. Monument

—8-24-14—M. & T.—2000 Bks.

46876

HEALTH DEPARTMENT—CITY OF BALTIMORE.

28 1046876

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Woodlawn Ave. and Hamilton Ave. St.; 27 WARD)
Raspeburg

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. F. Zwicker

Residence in Baltimore: No. Woodlawn Ave. St.; ...yrs. 40yrs. ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M.

4-COLOR OR RACE: W.

5-WHETHER SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): M.

DATE OF BIRTH: June 9th. (Month) (Day), 1868. (Year)

AGE: 52 yrs. ...mos. ...ds.

If LESS than 1 day, ...hrs. or ...min.?

OCCUPATION:
(a) Trade, profession, or particular kind of work: Baker 003
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Dont know

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Catherine Zwicker

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Marie Zwicker

(Address): Raspeburg

15- ROBERT J KLAUTER

Filed SEP 28 1920 191... Burial Permit Granted

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 25th. 1920, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1st. 1920 191..., to Sept. 25th. 1920 191..., that I saw him alive on Sept. 24th. 1920 191..., and that death occurred, on the date stated above, at 6A. M.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 5 yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) ...

(Duration) ...yrs. ...mos. ...ds.

(Signed) ... M. D.

..., 191... (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Sept. 28th. 1920

20-UNDERTAKER: Robert T. Turner Inc.

ADDRESS: #1442 N. Broadway

6-9-19—H. P. Co.—1000 Blks.

46877 HEALTH DEPARTMENT—CITY OF BALTIMORE 2046877

CERTIFICATE OF DEATH. 64

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

OF BALTIMORE: (No.) 1245 E. Lexington ST.: 5 WARD)

2-FULL NAME Lena Mueller

(a) RESIDENCE. No. 1245 E. Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life time mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Mueller

DATE OF BIRTH (month, day, and year) March 15-1865

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	6		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Lady D66

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Philipsbourne Store

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Lawrence Grove

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katharine Emlie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Smith

(Address) 1245 E Lexington St.

15 SEP 28 1920 ROBERT E KRAUSE Registrar

Burial Permit Oleft

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 20 1920 to Sept 26 1920

that I last saw her alive on Sept 26 1920

and that death occurred, on the date stated above, at 9.45 P.m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 326 N Howard

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Howard & Silver M. D.

(Address) 1914 Bolton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Sept 29 1920

20 UNDERTAKER William Cool ADDRESS 2025 Madison Ave

6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46878 V1046878

CERTIFICATE OF DEATH.

43

REGISTERED NO.

1-PLACE OF DEATH

Y OF BALTIMORE: (NO. 7 N. Broadway ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teresa Frischman

(a) RESIDENCE. NO. 7 N. Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Nov. 16-1860

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	10	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Frischman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gustina Heitzelbaner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie Frischman
(Address) 7 N. Broadway

15 Filed SEP 28 1920 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1920

17 I HEREBY CERTIFY, That I attended deceased from April, 1920, to Sept 26, 1920,

that I last saw h[illegible] alive on Sept 26, 1920,

and that death occurred, on the date stated above, at 10:20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the breast

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb 20

Was there an autopsy? No

What test confirmed diagnosis? Operation pathologic findings

(Signed) [illegible], M. D.

[illegible], 192[illegible] (Address) 24 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept 30 1920
20 UNDERTAKER	ADDRESS
Milton M. Jones	17 N. Broadway

c.—8-24-14—M. & T.—2000 Bks.

~~46879~~ HEALTH DEPARTMENT—CITY OF BALTIMORE ~~46879~~ 120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

ITY OF BALTIMORE: (No. 1350 N. Carey ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Murray

Residence in Baltimore: No. 1350 N Carey St. St.; 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, 3 (Month) 14 (Day) 1848 (Year)

7-AGE, 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 070
(b) General nature of industry, business, or establishment in which employed (or employer) Porter

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) JAMES H. DENNIS

(Address) 1303 PRESTMAN ST.

15-FILED SEP 28 1920 ROBERT E KRAUTER Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sunday Sept 26th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 20th 1920, to Sept 26th 1920, that I saw h in alive on Sept 25th 1920, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows: Arteriosclerosis Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hardening

(Duration) yrs. mos. ds.

(Signed) M. D.

Sept 27th 1920 (Address) 607 N Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL SEP 29 1920

20-UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

Spec.—8-24-14—M. & T.—2000 Bks.

46880

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46880

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 937 N. Collington Ave ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antonie Miller

Residence in Baltimore: No. 937 N. Collington Ave St.; 50 yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb 17, 1864 (Month) (Day) (Year)

7-AGE, 56 yrs. 7 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Antonin Bezrab

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Antonie Kavrosila

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Miller

(Address) 937 N. Collington Ave

15-

FILED SEP 28 1920 191.... ROBERT R [illegible] Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 26, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 12 1920, to Sept 26 1920, that I saw her alive on Sept 26 1920 and that death occurred, on the date stated above, at 11 10 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Chronic Endocarditis
Acute anasarca

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs

(Duration) yrs. mos. ds.

(Signed) M. Murnaghan M. D.

9-26-, 191... (Address) 800 N. Bethel St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Sept 29 191 20
20-UNDERTAKER	ADDRESS
Frank Brack Son	1916 Aisquith

959.

6-9-19 H. P. Co.—1000 Bks.

46881

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

69

D46881

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-PLACE OF DEATH

OF BALTIMORE: (No.) 502 Annapolis Ave. (St.) 25 (Ward)

2-FULL NAME Irene A. Seavey.

(a) RESIDENCE. No. 602 Annapolis Ave. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

DATE OF BIRTH (month, day, and year) July 12 1897

AGE	Years	Months	Days	If LESS than 1 day, ——— hrs. or ——— min.
23		2	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles W. Legg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Catherine D. Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Father (Address) 502 Annapolis Ave.

15 SEP 26 1920 ROBERT J. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1920

17 I HEREBY CERTIFY, That I attended deceased from 1912, 19—, to Sept 26, 1920, that I last saw h[illegible] alive on Sept 24, 1920, and that death occurred, on the date stated above, at 6:10 p. m.

The CAUSE OF DEATH was as follows:

Epilepsy

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Raymond J. Klaus, M. D.

, 19 (Address) 502 Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Sept 28 19 20

20 UNDERTAKER George J. Mill

ADDRESS [illegible]

...c.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46882 — 28D46882

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

...ITY OF BALTIMORE: (No.) 722 St Peters ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Williams

Residence in Baltimore: No. 722 St Peters St

St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Aug (Month) 6 (Day), 1866 (Year)

7-AGE, 54 yrs. 1 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Maude Leinde

(Address) 722 St Peters St

15- Filed SEP 28 1920, 191... [illegible] KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 26 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1920, to Sept 26 1920, that I saw her alive on Sept 25 1920, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) 1 yrs. mos. ds.

(Signed) Edw Marshall M. D.

9/28, 1920 (Address) 5[illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Sep 29, 1920

20-UNDERTAKER John J Cavan

ADDRESS 501 Hollins St

6-8-19—H. P. Co.—1000 Bks.

046883

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 1046883

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1503 Gough ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Banks

(a) RESIDENCE. NO. 1503 Gough ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	69	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Wm. Banks Jr.

(Address) 1503 Gough St.

15 [illegible] SEP 28 1920 ROBERT P. BRUCE Registrar

Burial Permit Only

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1920, to Sept 25, 1920, that I last saw he alive on Sept 25, 1920, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. 2 mos. 26 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Edward Fosbu, M. D.

, 19 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Sept 28 20

20 UNDERTAKER Clive V. Johnson ADDRESS 1107 N. Gordon

6-9-19—H. P. Co.—1000 Blks.

1046884

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046884

CERTIFICATE OF DEATH.

REGISTERED NO. 89

1-PLACE OF DEATH

TY OF BALTIMORE: (No. Mt Hope Retreat ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clavius Phillips

(a) RESIDENCE. NO. Savanah Ga - ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred since 1892 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

a If married, widowed, or divorced HUSBAND of (or WIFE of) Mrs Phillips

6 DATE OF BIRTH (month, day, and year) June 24 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
83	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Retired Cotton merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mobile Ala.

PARENTS

10 NAME OF FATHER Phillip Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charleston S. C.

12 MAIDEN NAME OF MOTHER Eugenia Levy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charleston S. C.

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 Filed SEP 28 1920 . 19

ROBERT B. KRAUTER Registrar

Burial Permit Oleis

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 19 20

17 I HEREBY CERTIFY, That I attended deceased from 1892 , 19—, to Sept 25 , 1920, that I last saw him alive on Sept 25, 1920, and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Melancholia (duration) 28 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Savanah Ga

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D

19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Savannah Ga — DATE OF BURIAL: Sept 28 1920

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D46885 — 64 D 46885

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Y OF BALTIMORE: (No.) 312 N Arlington Ave ST. 16 WARD)

2-FULL NAME John Deichmiller

(a) RESIDENCE. NO. 312 N Arlington Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 3 mos. ds. How long in U. S., if of foreign birth? 52 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary S. Deichmiller

DATE OF BIRTH (month, day, and year) Sept 22 1850

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	0	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Confectionery

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Sames Co.

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Peter Deichmiller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary S. Deichmiller

(Address) 312 N Arlington ave.

15 SEP 28 1920 LOUIS B KLAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25th 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 21 1920, to Sept 25 1920, that I last saw h. alive on Sept 25 1920, and that death occurred, on the date stated above, at 4.30 p m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Haemorrhage (duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Geo W Hendrickson M. D.

, 19 (Address) 800 Harlem ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls. Violetonville

DATE OF BURIAL 9-28 1920

ADDRESS

20 UNDERTAKER Wm Chas A. G. Rohde. 200 N Arlington Ave.

...—6-9-19—H. P. Co.—1000 Bks.

1

046886

HEALTH DEPARTMENT—CITY OF BALTIMORE

046886

CERTIFICATE OF DEATH.

Y 40

1-PLACE OF DEATH Church Home and Infirmary

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. Broadway & Fairmount Ave. ST.: 6 WARD)

2-FULL NAME Hyman Margoles

(a) RESIDENCE. No. Goldsboro, N. C. ST., WARD Goldsboro R 6.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Margoles

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Margoles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1411 E Balto St

15 Filed SEP 28 1920 ROBERT E KLAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 18. 1920. to Sept. 26. 1920.

that I last saw him alive on Sept. 26. 1920.

and that death occurred, on the date stated above, at 5:45 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver, origin undetermined

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Goldsboro, N. C.

Did an operation precede death? Yes Date of Sept. 21, 1920.

Was there an autopsy? No

What test confirmed diagnosis? Confirmed at Op.

(Signed) Walter T. Anderson, M. D.

Sept. 26, 1920 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Goldsboro N. C.	9/28 1920
20 UNDERTAKER Jack Lewis	ADDRESS 1411 E Balto

...c.—8-24-14—M. & T.—2000 Blks.

46887 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046887

CERTIFICATE OF DEATH.

63

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 133 N Collington ave 6 ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Caplan

Residence in Baltimore: No. 133 N. Collington ave St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec 14, 1868 (Month) (Day) (Year)

7-AGE, 52 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tailor 080
(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1441 E Balto St

15- Filed SEP 28 1920, 191.... ROBERT I KLAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 26, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 1915, to Sept 26 1920, that I saw him alive on Sept. 26 1920, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Progressive muscular atrophy

(Duration) 5 yrs. 8 mos. 26 ds.

CONTRIBUTORY (Secondary) Aortic insufficiency

(Duration) — yrs. — mos. 3 ds.

(Signed) Morris Abramenthal M. D.

Sept 26, 1920 (Address) 1707 E Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale

DATE OF BURIAL, 9-29, 1920

20-UNDERTAKER Jack Lewis

ADDRESS 1441 E Balto

...ec.—8-24-14—M. & T.—2000 Blks.

46888 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046888

CERTIFICATE OF DEATH.

REGISTERED NO. C 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 639 N. Calhoun ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura F. Delacour.

(Residence in Baltimore: No. 639 N. Calhoun St.; 70 yrs., 10 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single.

6-DATE OF BIRTH, Nov. - (?), 1849. (Month) (Day) (Year)

7-AGE, 70 yrs. 10 mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, James F. De Lacour

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Salome Entler.

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma A. De Lacour.

(Address) 639 N. Calhoun

15- Filed SEP 28 1920, 191.... ROBERT F. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 27, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 9 1920, to Sept 27 1920, that I saw her alive on Sept 27 1920, and that death occurred, on the date stated above, at 4 20 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Edema Hydrothorax

(Duration) 4 or 5 yrs. ....mos. ....ds.

(Signed) M Bernard Steck M. D.

Sept. 28., 1920. (Address) 626 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount — DATE OF BURIAL, Sept. 29, 1920

20-UNDERTAKER Geo W Little — ADDRESS 531 N Fremont Ave

Ida Mae Lecompte

...—6-9-19—H. P. Co.—1000 Bks.

946889

HEALTH DEPARTMENT—CITY OF BALTIMORE

946889

32

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

...Y OF BALTIMORE: (No. St. Agnes' Hospital WARD)

2-FULL NAME Mrs. Ida L. Lecompte

(a) RESIDENCE. NO. 2429 Harlem STREET WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Stephen Lecompte

7 DATE OF BIRTH (month, day, and year) July 9 1870

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	50	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James M. Forest

11 BIRTHPLACE OF FATHER (city or town) Ellicott City
(State or country) Howard Co., Maryland

12 MAIDEN NAME OF MOTHER Fannie E. Phoebus

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.

14 Informant Mrs. Stephen Lecompte
(Address) 2429 Harlem Ave

15 Filed SEP 28 1920 ROBERT I. KRAUTER Registrar
Burial Permit Oleet

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25 1920

17 I HEREBY CERTIFY, That I attended deceased from 8-30, 1920, to 9-25, 1920, that I last saw h-r alive on 9-25, 1920, and that death occurred, on the date stated above, at 12:30 m.

The CAUSE OF DEATH* was as follows:

Embolism

...(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Tuberculosis of Vertebral Spine

...(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) W. M. Craig, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 28 1920
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 West Balto St

—6-9-19—H. P. Co.—1000 Bks.

46890 HEALTH DEPARTMENT—CITY OF BALTIMORE D46890

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Y OF BALTIMORE: (No.) 27 N. Birkhead ST. 23 WARD)

2-FULL NAME Harry Charles Bowen

(a) RESIDENCE. No. 27 N. Birkhead ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 10 mos. ds. How long in U. S., if of foreign birth? 40 yrs. 10 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year) Nov. 17. 1879

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
40	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman on Steamer

(b) General nature of industry, business, or establishment in which employed (or employer): for Southern

(c) Name of employer: Transportation Co

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thomas H Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co Md

12 MAIDEN NAME OF MOTHER: Emma C. Porter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs Laura V. Smith (Address) 27 N Birkhead St

15 SEP 28 1920

16 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 . 1919. to Sept 27 . 1920., that I last saw h in alive on Sept 27 . 1920., and that death occurred, on the date stated above, at 10 40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Harry Gross, M. D.

9/28 1920 (Address) 1535 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Sept 1920

20 UNDERTAKER: C B Cook

ADDRESS: 1003 W Balt St

—6-9-19—H. P. Co.—1000 Bks.

246891

HEALTH DEPARTMENT—CITY OF BALTIMORE

246891

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 E. Eager ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Blanche L. Sherman

(a) RESIDENCE. NO. 815 E. Eager ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Myron Clark Sherman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kattstery New York

12 MAIDEN NAME OF MOTHER Edna Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Atlanty New York

14 Informant (Address) Myron C. Sherman 815 E. Eager

15 Filed SEP 28 19 ROBERT E [illegible] Registrar

Burial Permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1920, to Sept 27, 1920, that I last saw her alive on Sept 27, 1920, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows: acute ileo colitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 815 E. Eager

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D. Lee Magruder, M. D.

Sept 28 1920 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additionnl space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 30 1920

20 UNDERTAKER Elmer W Coinfelt ADDRESS 2476 Eager

6-9-19—H. P. Co.—1000 Bks.

D.46892

46892 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 759 N. Hamburg ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Reiss

(a) RESIDENCE. No. 759 N Hamburg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6. 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria Hungary

PARENTS

10 NAME OF FATHER Charles Reiss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria Hungary

12 MAIDEN NAME OF MOTHER Anna Kristek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria Hungary

14 Informant (Address) Mrs. Anna Dorsey 739 N. Hamburg St

15 Filed SEP 28 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 20. 1920. to Sept 27. 1920. that I last saw h[illegible] alive on Sept 27. 1920. and that death occurred, on the date stated above, at 7 4 m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Yes U&S Hospt

(Signed) Stephanie Dorsey, M. D.

, 19 (Address) 42 N Columbus Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery (Brooklyn	Sept 29 1920.
20 UNDERTAKER	**ADDRESS**
James Dignan & Son	1000 S Paca St

—6-9-19—H. P. Co.—1000 Bks.

V 20. 46893

20 46893 HEALTH DEPARTMENT—CITY OF BALTIMORE

30

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (NO. 2562 W. Balto ST.: 20 WARD)

2-FULL NAME Ruth N. Burgess

(a) RESIDENCE. NO. 2562 W. Balto ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 4, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER Frederick Burgess

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER Mary A Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant Frederick Burgess

(Address) 2562 W. Balto St

15 Filed SEP 28 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1920, to Sept 24, 1920, that I last saw her alive on Sept 24, 1920, and that death occurred, on the date stated above, at 9 P, m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) J. M. Lumpkin M. D.

(Address) 526 N Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: 9/28 1920

20 UNDERTAKER: Mrs. J. E. Saunders ADDRESS: 1218 E Chase

46894 HEALTH DEPARTMENT---CITY OF BALTIMORE 2.46894

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED NO. C 104

CITY OF BALTIMORE: (No. 1722 William St. St. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Emma Laura James

(Residence in Baltimore: No. like 1722 William St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female — 4-COLOR OR RACE White — 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH April 22 1920 (Month) (Day) (Year)

7-AGE 0 yrs 5 mos 4 ds. If LESS than 1 day, hrs., or min.? 000

8-OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Balto. Md.

PARENTS

10-NAME OF FATHER Earl Thomas James

11-BIRTHPLACE OF FATHER (State or country) Pinehall Ark.

12-MAIDEN NAME OF MOTHER Helen Elizabeth Martin

13-BIRTHPLACE OF MOTHER (State or country) Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Helen James

(Address) 1722 Williams St.

15- Filed SEP 28 1920 191 Robert P. Harrison, Burial Permit Clerk) REGISTRAR

ATTENTION is very important

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept. 26, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1920, to Sept. 26, 1920, that I saw her alive on Sept. 26, 1920, and that death occurred, on the date stated above, at 10:00 P m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum,

(Duration) yrs mos. 3 ds.

Contributory (SECONDARY) Convulsions

(Duration) yrs 2 mos. ds.

(Signed) [illegible] M. D.

Sept. 26, 1920 [Address] 1218 Hanover

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt Olivet Cem — DATE OF BURIAL Sept 28, 1920

20-UNDERTAKER John J Tobey Sons — ADDRESS 1318 Light St

c.—8-24-14—M. & T.—2000 Blks.

46895 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46895

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 E. 23rd. ST.; 17 WARD) REGISTERED NO. C 29

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Anne Hughes

Residence in Baltimore: No. 506 E. 23rd St. St.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE. White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May — (Month), (?) (Day), 1868 (Year)

7-AGE, 52 yrs. 4 mos. (?) ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Geo. Hewson

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Nora Cullen

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs L Hewson

(Address) 506E 23rd St

15-

Filed Sep 8 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 21st, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 26 1920, to Sept. 26 1920, that I saw h-r alive on Sept. 26th 1920, and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insuffic

(Duration) yrs. mos. 4 ds.

(Signed) Chas. E. Habliston M. D.

Sept 27, 1920 (Address) 324 E. Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Sykesville Md.

Former or usual residence Sykesville Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Sykesville Md	Sept 30, 1920
20-UNDERTAKER John J Tobyn	ADDRESS 1318 Light St

c.—8-24-14—M. & T.—2000 Bks.

46896

HEALTH DEPARTMENT—CITY OF BALTIMORE

No 46896

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED No. C.....

ITY OF BALTIMORE: (No. 4662 York Rd St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo R. Jacobs

Residence in Baltimore: No. 4662 York Rd St.; 24 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July 15 (Month) (Day), 1846 (Year)

7-AGE, 74 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Jacob Frank

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Mary Smith

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma R. Jacobs

(Address) 4662 York Rd

15- SEP 29 1920 ROBERT B. BRAUTIGAM
Filed....., 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 27, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9/20, 1920, to 9/27, 1920; that I saw h[illegible] alive on 9/24, 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH was as follows:

Broncho Pneumonia

(Duration) yrs. ds.

CONTRIBUTORY (Secondary) [illegible]

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

9/30, 1920 (Address) [illegible] Edau

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Loudon Park	Sept 29, 1920
20-UNDERTAKER Robt J Turner Inc	ADDRESS 1422 Pa Ave

6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~46897~~ 92-123 2046897

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St. Agnes' Hospital 20 WARD)

2-FULL NAME Mr. John F. Collins

(a) RESIDENCE. NO. 2516 Wilkens Ave WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	M.

If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Lillie Collins

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 015

(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " " "

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " " "

14 Informant Mrs. Lillie Collins
(Address) 2516 Wilkens Ave

15 FILED SEP 29 1920 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1920, to Sept. 27, 1920 that I last saw him alive on Sept 28, 1920 and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Peri-nephritis abscess with stone in kidney & ureter

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of Sept 24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. M. J. McCreary, M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 30 1920
20 UNDERTAKER George J. Smith	ADDRESS 1000 Fayette st

946898

HEALTH DEPARTMENT—CITY OF BALTIMORE

946898

CERTIFICATE OF DEATH.

1832

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 112 Ropewalk Lane. St. 23 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Taylor.(C)

(Residence in Baltimore: No. 114 Ropewalk Lane.

20 ---------- St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Married

6-DATE OF BIRTH, Do not know. (Month), 1 (Day), ... (Year)

7-AGE,	If LESS than 1 day,
30 yrs. ---------- mos. ---------- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None. 037
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), St Marys Co. Md.

PARENTS.

10-NAME OF FATHER, Samuel Bush.(C)

11-BIRTHPLACE OF FATHER (State or Country), St Marys Co. Md.

12-MAIDEN NAME OF MOTHER Susie.------(C)

13-BIRTHPLACE OF MOTHER (State or Country), St Marys Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Taylor.(C)husband.

(Address) 114 Ropewalk Lane.

15-

Filed SEP 29 1920 191.....

ROBERT E KRAUTER
Registrar.

Burial Permit Issued

important. See instructions on back.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 24th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inqst. & Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inqst. (Inquest, autopsy or inquiry.) & Autopsy find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage.
Stab wound in right side of neck, severing External Jugular vein.
Homocide.
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Sep 28 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Bel Air Md	Sept 29 1920
20-UNDERTAKER Samuel Bowersby	ADDRESS 718 N Broadway

...—6-9-19—H. P. Co.—1000 Bks.

46899

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 1046899

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2408 N. Charles ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Kauffman

(a) RESIDENCE. NO. 2408 N. Charles ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 87 yrs. 10 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Kauffman

6 DATE OF BIRTH (month, day, and year) Nov. 1, 1832

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	87	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John W. Bond

11 BIRTHPLACE OF FATHER (city or town) Hartford Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah A. Randall

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant John W. B. Kauffman
(Address) 2408 N. Charles Street

15 Filed SEP 29 1920 ROBERT F. KEITH Registrar

Burial Permit Clerk

TION is very Important

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27-1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24th, 1920, to Sept. 27th, 1920, that I last saw her alive on September 27th, 1920, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

Unknown (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hyper tension-Temp. Rales Areas Consolidation etc.

(Signed) Frederick J. Queen M. D.

. 19 (Address) 2827 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL 9/29, 1920

20 UNDERTAKER Henry W. Mears & Son 805

ADDRESS N. Calvert

046900 HEALTH DEPARTMENT—CITY OF BALTIMORE 046900

CERTIFICATE OF DEATH. 15 79 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1432 N. Mount ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Williams

(Residence in Baltimore: No. 1432 N. Mount St.: 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	married

6-DATE OF BIRTH, December 27, 1858 (Month) (Day) (Year)

7-AGE, 61 yrs. 8 mos. 30 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): (Team driver)

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Henry Williams

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Harriet Boon

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Chas. Williams

(Address) 1432 N. Mount St.

15- Filed SEP 29 1920, 191 ROBERT E. LEUTER Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 27, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) 2 yrs. mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Sept 28, 1920 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Sept. 29 1920

20-UNDERTAKER Edw. Ringgold

ADDRESS 1463 N. Carey

Important. See instructions on back.

6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B444 B2046901 — 28 2046901

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital; (WARD) 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arch Eggleston

(a) RESIDENCE. No. 1226 Parrish St.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. 18 mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

6 If married, widowed, or divorced, HUSBAND of (or) WIFE of: Sarah Eggleston

7 DATE OF BIRTH (month, day, and year) June 3-1887

AGE 33 Years 3 Months 24 Days. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffer 086

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER? Eggleston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Harriet Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: 7th Ward Board of H. (Address)

15 Filed SEP 29 1920 ROBERT F. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1920, to Sept 27, 1920, that I last saw h[illegible] alive on Sept 27, 1920, and that death occurred, on the date stated above, at 6:00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H Mason, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mathias Station — DATE OF BURIAL: Sept 29 1920

20 UNDERTAKER: Edw. Ringgold, Mathias Va — ADDRESS: 1463 N. Carey St.

...c.—6-9-19—H. P. Co.—1000 Bks.

046902

HEALTH DEPARTMENT—CITY OF BALTIMORE

046902

CERTIFICATE OF DEATH.

8-09

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (NO. 3719 Centre Place ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L. Updegraff

(a) RESIDENCE. NO. 3719 Centre Pl ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 15 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 22-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	1	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. City.
(State or country) Md.

PARENTS

10 NAME OF FATHER Harry Updegraff

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Irene Lang.

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Harry Updegraff
(Address) 3719 Centre Place

15 Filed SEP 29 1920 ROBERT B. LEAUTER Registrar

Burial Permit Clerk

CAUSE OF DEATH. TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 7th, 1920, to Sept 28, 1920, that I last saw him alive on Sept 28th, 1920, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Whooping Cough 3 weeks

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Adam Ford. M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Sept. 29 1920
20 UNDERTAKER Lilly and Fuhr	ADDRESS 403 Lnx

046903 HEALTH DEPARTMENT--CITY OF BALTIMORE ✓ 046903.

CERTIFICATE OF DEATH

REGISTERED NO. C 79

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 313 N Robinson ST.: 6 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Frederick Wohl

(Residence in Baltimore: No. 313 N Robinson St.: 15 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married.

6 DATE OF BIRTH July (Month) 5 (Day), 1888 (Year)

7 AGE 32 yrs. 2 mos. 23 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Carpenter 015
(b) General nature of industry, business, or establishment in which employed (or employer) Clement & Co. Ltd.

9 BIRTHPLACE (State or country) Germany.

PARENTS

10 NAME OF FATHER John Wohl

11 BIRTHPLACE OF FATHER (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Germany.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ellen Wohl.

(Address) 313 N. Robinson St.

15.

Filed SEP 29 1920 191 ROBERT E KRAUTER REGISTRAR
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 28 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10 July, 1920, to 28 Sept 1920 that I saw h[illegible] alive on Sept 28, 1920. and that death occurred, on the date stated above, at 8.30 P m. The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

To my knowledge (Duration) yrs. 2 mos. ds

Contributory (SECONDARY) Aortic insufficency

To my knowledge (Duration) yrs. 2 mos. ds.

(Signed) [illegible] M. D.

28 Sept, 1920 (Address) 301 N Ellwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Pchwartz Cem. DATE OF BURIAL Sept. 30, 1920.

20 UNDERTAKER Lilly and Zeib ADDRESS 403 S. Wolfe

is very important. See instructions on back

1046904 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046904

159

CERTIFICATE OF DEATH.

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 404 S Paca St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Davis

(Residence in Baltimore: No. 404 South Paca St.: yrs. 73 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Nov. 11, 1846
(Month) (Day) (Year)

7-AGE, 73 yrs. 10 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired D4
(b) General nature of industry, business, or establishment in which employed (or employer): Shell Mette

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Davis

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary M Davis

(Address) 404 S Paca St

15- SEP 23 1920 ROBERT B KLAUTER
Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 22, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Bullet Wound Left Temple
Brain Lacerated
Suicide
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James McFerson M. D.
(Coroner.)
Sept 22 1920 (Address) 740 E Chase St

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Sept 30, 1920
20-UNDERTAKER	ADDRESS
John J Fields	1200 W Fayette St

ec.—8-24-14—M. & T.—2000 Bks.

946905

HEALTH DEPARTMENT—CITY OF BALTIMORE

946905

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH Hebrew Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.

2-FULL NAME Mrs Johanna Schuppel

Residence in Baltimore: No. Hebrew Hosp. Asylum St.; 60 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, unknown (Month) (Day) 1 (Year)

7-AGE 88 yrs. 1 mos. da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Hosp. Record

(Address) Hebrew Hospital

15- SEP 29 1920 ROBERT F. KRAUTER

Filed....., 191..... Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 27, 1920 A.M. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27 1920, to Sept 27 1920, that I saw h e alive on Sept 27 1920 and that death occurred, on the date stated above, at 9:55 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Bilateral Hydrothorax

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) yrs. mos. 1 da.

(Signed) H. Mejer M. D.

Sept 28, 1920. (Address) Hebrew Hosp Asylum

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence Hebrew Hosp Asylum

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew Cem DATE OF BURIAL, 9 29, 1920

20-UNDERTAKER David Sondheim ADDRESS 1183 W Lexington

6-9-19—H. P. Co.—1000 Bks.

Mozer.

946906 HEALTH DEPARTMENT—CITY OF BALTIMORE 946906

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2100 Linden Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Mozer

(a) RESIDENCE. NO. 2101 Linden Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Mozer

7 DATE OF BIRTH (month, day, and year) Dec 3 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Abraham Rothschild

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka Goldsmith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Rothschild 2101 Linden

15 Filed SEP 29 1920, 19.. ROBERT T. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 2 1920, to Sept 28th 1920, that I last saw h[illegible] alive on Sept. 28th 1920, and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

General Debility.
Chronic nephritis
Valvular heart disease

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] Goldberg, M. D.

19 (Address) 2210 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodmere	Sept 30th 1920

20 UNDERTAKER Kurd Bondheim ADDRESS 1184 W. Baltimore St

cc.—8-24-14—M. & T.—2000 Bks.

46907 HEALTH DEPARTMENT—CITY OF BALTIMORE 46907

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2448 Francis ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adelaide Morgenweck

Residence in Baltimore: No. 2448 Francis St.; 50 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March (Month) 31 (Day), 1846 (Year)

7-AGE, 74 yrs. 5 mos. 28 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ~ 037
(b) General nature of industry, business, or establishment in which employed (or employer) ~

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Schleup

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Johanna Schleup

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Marie Schleup

(Address) 2448 Francis ST.

15- SEP 29 1920 ROBERT B KRAUTER

Filed ....., 191.... Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 4 1920, to Sept 27 1920, that I saw her alive on Sept 27 1920, and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(Duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) E. C. Hesser M. D.

Sept 28 1920 (Address) 1301 N. Pat. Pk. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ~

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Westview Cem. | DATE OF BURIAL, ..., 191...

20-UNDERTAKER Joseph Syfer | ADDRESS Bonaparte

pcc.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2046908

46908

CERTIFICATE OF DEATH.

151 REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1242 E. Madison ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of James L. and Rebecca Wett.

(Residence in Baltimore: No. 1242 E. Madison St ..... St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept (Month) 28 (Day), 1920 (Year)

7-AGE, ... yrs. ..... mos. 2 ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. James L. Wett.

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Rebecca Montgomery.

13-BIRTHPLACE OF MOTHER (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James L. Wett.

(Address) 1242 E. Madison St.

15- SEP 29 1920

Filed ..... 191.... ROBERT J. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 28 1920, to Sept 29 1920, that I saw her alive on Sept 28 1920, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

(a) Premature birth

(b) Congenital debility

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Dame M. D.

Sept 29, 1920 (Address) 1 East Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Sept 29, 1920

20-UNDERTAKER Frank A. Fink

ADDRESS 910 N. Gay St.

...6-9-19—H. P. Co.—1000 Bks.

946909

HEALTH DEPARTMENT—CITY OF BALTIMORE

946909

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

2-FULL NAME Mary Boyer or Byrd

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widwo

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

7 DATE OF BIRTH (month, day, and year) 1861

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress 041
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, New City Hospital.
(Address)

15 Filed SEP 29 1920 19.. Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26, 1920

17 I HEREBY CERTIFY, That I attended deceased from January 3, 1920, to Sept. 26, 1920.
that I last saw her alive on September 26, 1920.
and that death occurred, on the date stated above, at 10:30 P. m.
The CAUSE OF DEATH* was as follows:
Arterio-sclerosis with cerebral hemorrhage
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension.
(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? Yes.
What test confirmed diagnosis? No special test.
(Signed) Bateman, M. D.
9/25/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashury Cemety — DATE OF BURIAL Sept 29 1920

20 UNDERTAKER John H Owens — ADDRESS 5-38 22nd

Dec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

046910 — 2046910

CERTIFICATE OF DEATH.

REGISTERED NO. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1833 Bell ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Virginia Moon

Residence in Baltimore: No. 1833 Bell Street St.: yrs., 3 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) S.

6-DATE OF BIRTH. June (Month) 12 (Day), 1920 (Year)

7-AGE. 3 yrs. mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. John Moon

11-BIRTHPLACE OF FATHER (State or Country). Caroline Co. Va

12-MAIDEN NAME OF MOTHER Grace Goode

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Mr. John Moon

(Address) 1833 Bell St.

15- Filed SEP 29 1920, 191... ROBERT E. KRAUTER Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. September (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 7 1920, to Sept 28 1920, that I saw h[er] alive on Sept 28 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Cholera Infantum

(Duration) yrs. mos. 14 ds.

(Signed) John H. Holland M. D.

Sept 28, 1920. (Address) 638 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State.. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1833 Bell St.

19-PLACE OF BURIAL OR REMOVAL. Cedar Hill Cemetery

DATE OF BURIAL. Sept 30, 191..

20-UNDERTAKER John Howard & Son

ADDRESS 908 Eutaw St

ec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 28 046911

46911

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 S Vincent ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carthur F Harshbarger

Residence in Baltimore: No. 410 S Vincent

St.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Oct (Month) 2 (Day), 1877 (Year)

7-AGE. 42 yrs. 11 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Painter (b) General nature of industry, business, or establishment in which employed (or employer) 63

9-BIRTHPLACE. (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Charles H Harshbarger

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Mary F Fowler

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Iona Harshbarger

(Address) 410 S Vincent

15- SEP 29 1920 ROBERT I KRAUTER

Filed....., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 27 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 10 1919, to Sept 27 1920, that I saw h[illegible] alive on Sept 27 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Edward M. C. Carter M. D.

Sept 29, 1920 (Address) 114 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Bem

DATE OF BURIAL, Sept 30, 1920

20-UNDERTAKER H M Routson

ADDRESS 230 N Greene

6-9-19—H. P. Co.—1000 Blks.

D 46912

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46912

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1332 Andrew ST.: 24 WARD)

2-FULL NAME Ignac Rulka

(a) RESIDENCE NO. 1332 Andrew ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: School Boy

6 DATE OF BIRTH (month, day, and year): Sept 24. 1914

7 AGE — Years: 6 — Months: 0 — Days: 22 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Indiana

PARENTS

10 NAME OF FATHER: Ignac Rulka

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Katherine Bettgner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Ignac Rulka 1332 Andrew

15 Filed SEP 23 1920 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28 1920 9 A.M. to Sept. 28 1920 5 P.M. that I last saw him alive on Sept. 28 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Toxemia + asphyxia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Hm

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician's Microscopical

(Signed) Morris Abramowitz M. D.

19 (Address) 1707 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brooklyn Holy Cross Cemetery — DATE OF BURIAL: Sept 30 1920

20 UNDERTAKER: E W Conklin — ADDRESS: 924 E Eager St

BOBERT P. LAMB
Burial Permit Clerk

6-9-13 H. P. Co.—1000 Blks.

D46913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46913

CERTIFICATE OF DEATH.

91

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No 4890 Reisterstown Rd WARD 27

2-FULL NAME Robert J. McNara

(a) RESIDENCE. No 4820 Reisterstown Rd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 25 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER J. J. O'Mara

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Daisy Davies

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) A. J. O'Mara 4890 Reisterstown Rd

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 . 1920 . to Sept 28 . 1920.

that I last saw him alive on Sept 28 . 1920.

and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. W. Dorsey M. D.

. 19 (Address) 720 N. Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL Sept 30 1920

20 UNDERTAKER Martin Fahey & Sons ADDRESS 1527 N. Mont Ave

Meany.

Rec. 6-9-19—H. P. Co.—1000 Bks.

D 46914 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 46914

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: No. Mount Hope Retreat St. 738 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry S. Meany

(a) RESIDENCE. No. Louisville Ky St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 25 - 1845

7 AGE: Years 75; Months 0; Days 0; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Civil Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS

10 NAME OF FATHER E. A. Meany

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cork Ireland

12 MAIDEN NAME OF MOTHER Marie L. Shannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Records of Mt. Hope Retreat Mt. Hope Md.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1925

17 I HEREBY CERTIFY, That I attended deceased from May 1890 ~~19~~, to Sept 25 1925, that I last saw h... alive on Sept 25 1925, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis. (Paraplegia)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) 47 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Louisville Ky

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt. Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Catholic Cemetery

DATE OF BURIAL: Sept 1925

20 UNDERTAKER: J. S. SLOAN & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

...—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 46915 ✓ X 104 D 46915

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Wayne Shroyer

(a) RESIDENCE. NO. Westminster ave ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. / mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14-'20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Montgomery J. Shroyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER Marie Nolen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant [illegible]

(Address)

15 Filed ..., 19 ...

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28, 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 11, 1920, to Sept 28, 1920, that I last saw h[illegible] alive on Sept 28, 1920, and that death occurred, on the date stated above, at 8 PM a.m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(Not whooping)

(duration) 5 yrs. — mos. 30 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? No.

(Signed) E. C. Dixon, M. D.

, 19 (Address) 1 H H. Balt, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Federalsburg Md Westminster Bd

DATE OF BURIAL: Sept 29 1920

20 UNDERTAKER W M Rowson

ADDRESS 2301 N Eutaw

D 46916 HEALTH DEPARTMENT—CITY OF BALTIMORE D 46916

CERTIFICATE OF DEATH.

REGISTERED NO. C 19

1 PLACE OF DEATH
CITY OF BALTIMORE (No. 1921 Alice Anna ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ruth Czarnocki

(Residence in Baltimore: No. 1921 Alice Anna St. St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male,	White,	Married,

6-DATE OF BIRTH, March (Month) 19- (Day), 1873. (Year)

7-AGE. 47 yrs. 6 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Day labor,
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country), Poland,

PARENTS.

10-NAME OF FATHER, Frank Czarnecki,

11-BIRTHPLACE OF FATHER (State or Country). Poland,

12-MAIDEN NAME OF MOTHER Katharine **********

13-BIRTHPLACE OF MOTHER (State or Country). Poland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

W F. Sadowski for Rosalia Czarnecki
(Informant)

(Address) 1921 Aliceanna Street

15-

Filed....., 191.... Registrar.

ROBERT B KRAUTER
SEP 29 1920
Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 27 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) ... yrs. ... mos. 14 ds.

Brain Embolism

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. 1 ds.

(Signed) ... M. D.
(Coroner.)

9/27/20, 191... (Address) 143 N. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem., DATE OF BURIAL, Sept. 30, 1920.

20-UNDERTAKER W F. Sadowski ADDRESS 705 S. Ann St.

c.—6-9-19—H. P. Co.—1000 Bks.

1046917 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046917

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Magnolia N. of Rockdale Ave. ST.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David M. Divan

(a) RESIDENCE. NO. Magnolia ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lana V. Divan

6 DATE OF BIRTH (month, day, and year): May 15, 1849

7 AGE: Years 71 | Months 4 | Days 12 | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: R.R. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): B&O

(c) Name of employer: B & O R R.

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown.

14 Informant: Lana V. Divan

(Address): 1 Magnolia Ave.

Filed SEP 29 1920 ROBERT E KLAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 27 1920

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1920, to Sept 29, 1920, that I last saw him alive on Sept 26, 1920, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Hawkins M. D.

9/29, 1920 (Address) 1 E Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: 9/29 19

20 UNDERTAKER: Mrs. J. E. Lewis — ADDRESS: 1425 N. A

...—6-9-19—H. P. Co.—1000 Bks.

046918

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 046918

14

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. Johns Hopkins Hospital ST.: 1st WARD)

2-FULL NAME Frank Keerans

(a) RESIDENCE. No. 731 S Decker Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 16-1918

7 AGE 2 Years 1 Months 13 Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER Frank Keerans

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Villa Dennastus

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant J H H Record
(Address) J. H. H.

15 Filed SEP 29 1920 ROBERT F. KRAUTER Registrar
Burial permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1920, to Sept 28, 1920, that I last saw h alive on Sept 28, 1920, and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? None yet

(Signed) W D Davison, M. D.

, 19 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Staunton Va

DATE OF BURIAL: Sept 30 1920

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans

rec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46919 ✓ D.46919

CERTIFICATE OF DEATH.

REGISTERED NO. 37

1. PLACE OF DEATH
CITY OF BALTIMORE: (No. Plain Farms ST. 28 WARD) — Catonsville

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Lavinia Streett

(a) RESIDENCE. NO. Plain Farms ST., Arlington WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Dr. Chas N. Streett

6 DATE OF BIRTH (month, day, and year) Nov 9 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	10	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 086
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

10 NAME OF FATHER Roger Street

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co

12 MAIDEN NAME OF MOTHER Louisa Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co Md

14 Informant (Address) Mr. Louis Ryan 4749 Park Heights Av

15 Filed Sep 29 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 22 1915 to Sep 28 1920.
that I last saw he alive on Sep 28 1920, at 12.30 P. m.
and that death occurred, on the date stated above, at 12.30 P. m.
The CAUSE OF DEATH* was as follows: OVER

Tabes Dorsalis
(duration) 4 yrs. 10 mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? —
What test confirmed diagnosis? —

(Signed) John D. Bubert, M. D.
Sep 28 1920 (Address) 4854 Park Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Fallston. Md — DATE OF BURIAL Oct 1 1920

20 UNDERTAKER Wm J Pickerston — ADDRESS N Pa

Waligorski

D. 46920

Rec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 46920

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 S. Decker Ave. WARD) 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Waligorski

(a) RESIDENCE. No. 1218 S Decker Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 15 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Joseph Waligorski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Toledo Ohio

12 MAIDEN NAME OF MOTHER Mary Franiakowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant (Address) Joseph Waligorski 1218 S. Decker Ave

15 Filed SEP 29 1920 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-28-1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 18 1920, to Sept 28 1920.

that I last saw him alive on Sept. 18 1920.

and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Inanition

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L Wisner M. D.

9-28 1920 (Address) 30 S. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem

DATE OF BURIAL Sept 30 1920

20 UNDERTAKER Stephen J. Fiolkowski

ADDRESS 1001 S. Howard ave

TION is very important.

pec.—8-24-14—M. & T.—2000 Bks.

2.46921

HEALTH DEPARTMENT—CITY OF BALTIMORE

2.46921

152

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1747 E. Eager ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret C. Sadler

(Residence in Baltimore: No. 1747 E Eager St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept. 26, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Blanchard Sadler

11-BIRTHPLACE OF FATHER (State or Country), Tennessee

12-MAIDEN NAME OF MOTHER Edna E. Horsfall

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanchard Sadler

(Address) 1747 E. Eager st

15-

FEB 2 9 1920

Filed....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 28, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 26 1920, to Sept. 28 1920, that I saw h— alive on Sept 28 1920, and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Injuries by Forceps at birth

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) ....yrs. ....mos. 1 ds.

(Signed) Chas. B. Leighton M. D.

Sept. 29 1920 (Address) 8 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cem. DATE OF BURIAL, Sept. 29 1920

20-UNDERTAKER D. G. Schaeffer ADDRESS 1816 E. Monument

...—6-9-19—H. P. Co.—1000 Bks.

0.46922 HEALTH DEPARTMENT—CITY OF BALTIMORE 0.46922

CERTIFICATE OF DEATH. X 109

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

TY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

2-FULL NAME Samuel Johnson

(a) RESIDENCE. No. Texas, Maryland ST.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 1 ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): October 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer): Farming

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Texas Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Unknown

14 Informant: W. J. Chatterton
(Address): Phoenix Md

15 Filed SEP 29 1920, 19... Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 28 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1920, to Sept. 28, 1920, that I last saw him alive on Sept. 28, 1920, and that death occurred, on the date stated above, at 1:05 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated Rt. inguinal Hernia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) 10 hrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) W. D. Davis, M. D.

9/28 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional items.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cockeysville Md	Sept 29 1920
20 UNDERTAKER: Samuel Hemsley	ADDRESS: 678 W Balto

(over)

Spec.—8-24-14—M. & T.—2000 Blks.

46923 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46923

CERTIFICATE OF DEATH. 1-64

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 N. Exeter ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria Bolintari

(Residence in Baltimore: No. 303 N. Exeter St St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE. white | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March (Month) ....., 1864. (Day) (Year)

7-AGE. 56 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Tailor (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Italy

PARENTS.

10-NAME OF FATHER. Ioanne Bolintari

11-BIRTHPLACE OF FATHER (State or Country). Italy

12-MAIDEN NAME OF MOTHER Concetta Cassata

13-BIRTHPLACE OF MOTHER (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jom. Summella

(Address) 306 East st

15- FEB 29 1920 Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Cle

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 28 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1920, to Sept 28 1920, that I saw her alive on Sept 28 1920 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

Cerebral Haemorrhage

CONTRIBUTORY (Secondary) (Duration) 2 yrs. mos. ds.

(Signed) Luigi D. DeSalvo M. D.

Sept 29, 1920 (Address) 407 N. Exeter St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cem. | DATE OF BURIAL. Sept 30 1920

20-UNDERTAKER George J. Rutt | ADDRESS 1735 Hanford ave

...—6-9-19—H. P. Co.—1000 Bks.

~~43389~~ D. 46924

HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46924

CERTIFICATE OF DEATH. X 104

~~43389~~ D. 46924

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (St.:) (Ward) 7

2-FULL NAME Adna Lee Hubbard

(a) RESIDENCE. No. 3rd ave (Usual place of abode) Waynes Point (St.) Md (Ward.)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Hubbard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida Hurley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) J H H.

15 Filed SEP 29 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1920, to Sept. 28, 1920, that I last saw h Ez alive on Sept. 28, 1920, and that death occurred, on the date stated above, at 11 55 P m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(not dysentery)

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Dr.

(Signed) A W Dawson, M. D.

, 19 (Address) 1 H H. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge & Dorchester Co's	Sept 30 1920
20 UNDERTAKER	ADDRESS
Margaret E. Flynn	1422 Light St.

D. 46925 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46925

CERTIFICATE OF DEATH.

103

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1206 Chatham St. 8 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Williams

(Residence in Baltimore: No. 1206 Chatham St. Ste St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-~~SINGLE~~ MARRIED, ~~WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, July 18, 1887.
(Month) (Day) (Year)

7-AGE, 33 yrs. 2 mos. 10 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, John Carroll

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Alice Smith

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Williams

(Address) 1206 Chatham St

15-

Filed ....., 191.....

SEP 29 1920

Robert P. Harrison,
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9/28, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Gastritis

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Zellmer Bates M. D.
(Coroner.)

9/29/20, 191... (Address) 143 N Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, 9/30, 1920

20-UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave.

Important. See instructions on other side.

Spec.—8-24-14—M. & T.—2000 Bks.

2.46926 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46926

CERTIFICATE OF DEATH.

REGISTERED No. C 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2804 E Fairmount ave 6 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna L Hurley

(Residence in Baltimore: No. 2804 E Fairmount ave St.; 7 yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Sept 22 (Month) (Day), 1850 (Year)

7-AGE, 70 yrs. mos. 6 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Richard Farrell

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Elizabeth Stewart

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Dibbern

(Address) 2804 E Fairmount ave

15-

Filed ....., 191.....

Registrar.

P 9.9.1920 Robert F ...

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 25 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 10 1917, to Sept 25, 1920, that I saw her alive on Sept 27 1920, and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 3 yrs. 8 mos. 18 ds.

CONTRIBUTORY (Secondary) Uremia, convulsions

(Duration) yrs. mos. 8 ds.

(Signed) Chas B. Fleagle M. D.

Sept 28, 1920 (Address) 830 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery

DATE OF BURIAL, Sept. 30, 1920

20-UNDERTAKER Mrs C. Miller

ADDRESS 2334 Jefferson

c.—6-9-19—H. P. Co.—1000 Bks.

1046927 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046927

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.

ITY OF BALTIMORE: (No. 3303 Park Circle ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Rosina Schaumloeffel

(a) RESIDENCE. NO. 3303 Park Circle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicolaus Schaumloeffel

6 DATE OF BIRTH (month, day, and year) May 9. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of Industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10 NAME OF FATHER Johann Bartady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Mary B. Stoler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

TION is very important

14 Informant C. Edward Schaumloffel (Address) Woodlawn

15 Filed SEP 30 1920 ROBERT F. LEUTER Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 1920 to Sept 28 1920

that I last saw ~~she~~ alive on Sept 27 1920

and that death occurred, on the date stated above, at 7 15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. Theo Koeneke, M. D.

(Address) 34 36 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem. DATE OF BURIAL Oct 1 1920

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Park Ave

...—6-9-19—H. P. Co.—1000 Bks.

1046928 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046928

105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1129 Hanover St ST.: 12 WARD)

2-FULL NAME Edward Taylor

(a) RESIDENCE. NO. 1129 Hanover St, ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Col.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rockland Co Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant W Cole

(Address) 1429 Hanover St

15 Filed SEP 30 1920 19 ROBERT I KRAUTER Registrar

Burial Permit Oiled

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/27/20

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1920, to Sept 27, 1920, that I last saw h... alive on Sept 27, 1920, and that death occurred, on the date stated above, at 11:45 p.m.

The CAUSE OF DEATH* was as follows:

Acute General Peritonitis
Acute General Peritonitis
and Exhaustion

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion of Injury

(duration) 3 yrs. 10 mos. ? ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) Geo L Ball, M. D.

, 19 (Address) 426 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 30 1920
20 UNDERTAKER Samuel L Hemsley	ADDRESS 538 E Biddle

D46929 HEALTH DEPARTMENT—CITY OF BALTIMORE D46929

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Lenox Lane x Madison sts. ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amanda E Frank

(Residence in Baltimore: No. Lenox Lane x Madison sts St.; yrs., Fife mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Nov 4, 1841
(Month) (Day) (Year)

7-AGE, 78 yrs. 10 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Johnson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Not none

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R L Frank

(Address) Lenox Lane x Madison

15-

Filed SEP 30 1920 ROBERT F. HAUTEN, 191.... Registrar.

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. C. Bates M. D.
(Coroner.)

9-28-, 191... (Address) 1431 No. Paca

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Trinity Cemetery	Sept 30, 1920

20-UNDERTAKER	ADDRESS
Jas C Miller	2334 Jefferson

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 846930

846930 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 S Third St. ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles. H. Ebert.

(Residence in Baltimore: No. 918 S Third St. St.; 30 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~. (Write the word.) Married

6-DATE OF BIRTH. April 31, 1868. (Month) (Day) (Year)

7-AGE. 52 yrs. 6 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Baker
(b) General nature of industry, business, or establishment in which employed (or employer). 003

9-BIRTHPLACE, (State or Country). Germany.

PARENTS.

10-NAME OF FATHER. Frederick Ebert.

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Margaret. Erhardt

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Lehmann

(Address) 918 S. Third St.

15- SEP 30 1920 ROBERT F. BRAUER BUREAU PERMITS

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 28, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 8 1920, to Sept. 27 1920, that I saw h~~im~~ alive on Sept. 27 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) H. B. Kelly M. D.

9/29, 1920 (Address) 2306 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oak Lawn Cemetery

DATE OF BURIAL, Oct 1st, 1920

20-UNDERTAKER Wm C. Miller

ADDRESS 2334 Jefferson St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

846931 846931

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Church Home and Infirmary (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (a) NO. N. Broadway & Rosemont Ave ST.: WARD)

2-FULL NAME Mrs. Mary Sproul

(a) RESIDENCE. NO. 1524 Kanawha St. Charleston, W. Va. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oliver J. Sproul

6 DATE OF BIRTH (month, day, and year) September 4 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Charleston W. Va

PARENTS

10 NAME OF FATHER R. J. Southerthwait

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charleston W Va

12 MAIDEN NAME OF MOTHER Anna Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant (Address) Oliver J. Sproul Charleston W. Va.

15 Filed . 19 ROBERT E. LAUTER Registrar

THIS is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1920, to Sept. 29, 1920, that I last saw h[illegible] alive on Sept. 29, 1920, and that death occurred, on the date stated above, at 10:00 a. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach with Metastasis.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Charleston, W. Va.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Walter T. Anderson, M. D.

9/29/1920 (Address) Church Home & Infir.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charleston. W. Va

DATE OF BURIAL Sept 30 1920

20 UNDERTAKER Wm J Tickner & Sons

ADDRESS N. Pa

6-3-19—H. P. Co.—1000 Blks.

D 46932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 79 D 46932

REGISTERED NO.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (NO.) Wilkins Ave (ST.) 18 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Gladstone

(a) RESIDENCE. NO. 844 W. Lombard ST., WARD. Newham N6.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. Car. Durhim

PARENTS

10 NAME OF FATHER Yules

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Fanny Grandey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: J Lewis (Address) 1411 Eutaw st

15 Filed SEP 30 1920 ROBERT P. LEACH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-30 1920

17 I HEREBY CERTIFY, That I attended deceased from 8/18/20, 19 , to 9/20/20, 19 , that I last saw her alive on 9/30/20, 19 , and that death occurred, on the date stated above, at 4:50 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) W. M. Craig, M. D.

9/30 1920 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem

DATE OF BURIAL: 9/30 1920

20 UNDERTAKER: Jack Lewis

ADDRESS: 1411 Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

846933 HEALTH DEPARTMENT—CITY OF BALTIMORE 19 D46933

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U S P H S Hospital #56 REGISTERED NO.

CITY OF BALTIMORE: (NO Fort McHenry Balto, Md. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Warren Hutter

(a) RESIDENCE. NO. U S P H S Hospital #56. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48 years	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaman

(b) General nature of industry, business, or establishment in which employed (or employer): unknown

(c) Name of employer: unknown

9 BIRTHPLACE (City or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant E.T. Raubut
(Address) Registrar Ft McHenry Md.

15 Filed SEP 30 1920 19 ROBERT E. LEAUTER Registrar
Burial Permit Clerk

TION is very important. See instructions

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept, 27/20

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15 1920. to Sept, 271920 that I last saw him alive on Sept, 27 1920 and that death occurred, on the date stated above, at 845a.m.

The CAUSE OF DEATH* was as follows:

Dilatation, acute, cardiac, Chroni
Endocarditis, Nephritis, acute.
Hernia Inguinal.

unknown (deration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Thomas R. Payne M. D

, 19 (Address) Fort Mc Henry Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 30 1920
20 UNDERTAKER: David Eastwood	ADDRESS 916 Pa ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

D46934 HEALTH DEPARTMENT—CITY OF BALTIMORE D46934

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3319 Myrtle pl. ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Yurek.

(a) RESIDENCE. No. 3319 Myrtle pl. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of " "

6 DATE OF BIRTH (month, day, and year) July 10-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Yurek.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Foltz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant James Yurek
(Address) 3319 Myrtle pl Holes

15 Filed ....., 19 .....
Registrar

SEP 30 1920 Vital Records Office

THIS is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1920, to Sept 29, 1920, that I last saw him alive on Sept 29, 1920, and that death occurred, on the date stated above, at 2 45 a. m.

The CAUSE OF DEATH* was as follows:

Enterocolitis

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) [illegible] M. D.

9/29 1920 (Address) 3307 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary.	Sept 30 1920

20 UNDERTAKER Wm Galloway

ADDRESS 168 Eastern Ave

Spec. 6-9-19 H. P. Co. 1000 Bks.

1046935

HEALTH DEPARTMENT—CITY OF BALTIMORE

29 1046935

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James C. Gore

(a) RESIDENCE. NO. 208 E. Lafayette Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Gore

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER John S. Carruthers

11 BIRTHPLACE OF FATHER (city or town) England (State or country)

12 MAIDEN NAME OF MOTHER Sarah Avalon

13 BIRTHPLACE OF MOTHER (city or town) England (State or country)

14 Informant Lelia C. Featherbury (Address) 208 E. Lafayette Ave

15 Filed SEP 30 1920 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1920

17 I HEREBY CERTIFY, That I attended deceased from August 15, 1920, to Sept 28, 1920, that I last saw her alive on Sept 28, 1920, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. Wilbur Stewart. M. D.

9/29, 1920 (Address) Maryland General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL Sept 30 1920

20 UNDERTAKER John Oursler ADDRESS 1201 W. Fayette St.

TION is very important. See Instructions on

Spec.—8-24-14—M. & T.—2000 Bks.

046936

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46936

30

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sadye E. Salabes.

(Residence in Baltimore: No. Alhambra apts 1-H St.; ..... yrs., ... mos. ..... ds.)

Linden Ave & Park Ave

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, March 19, 1909.
(Month) (Day) (Year)

7-AGE, 11 yrs. 6 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Meyer S. Salabes

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Katherine Spear

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Meyer S. Salabes

(Address) Alhambra Apts

15- SEP 30 1920 ROBERT B KRAUTER

Filed ..... 191. ..... Asst. Clerk

SEP 30 1920 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 28, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 19 1920, to September 1920, that I saw h[illegible] alive on September 28 1920, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(Duration) ..... yrs. ..... mos. 2 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Manuel G. Gerber M. D.

Sept 28., 1920. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 9 ds. In the State 11 yrs. 6 mos. ..... ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence Alhambra Apt.

19-PLACE OF BURIAL OR REMOVAL, Balto Hebrew

DATE OF BURIAL, Sept. 30., 1920.

20-UNDERTAKER Harry Goodman

ADDRESS 1010 W Fay

pec.—6-9-19—H. P. Co.—1000 Bks.

D 46937

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46937

CERTIFICATE OF DEATH.

REGISTERED NO. 40

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred W Della

(a) RESIDENCE. No. 301 W. Madison ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brickmakers

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Della

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hester D.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Clara Bolk

(Address) 1418 Riverside Ave

15 Filed ....., 19.. ..... Registrar

SEP 30 1920 Burial Permit Clerk

TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/29 1920

17 I HEREBY CERTIFY, That I attended deceased from 9/11, 1920, to 9/29, 1920 that I last saw him alive on 9/29, 1920 and that death occurred, on the date stated above, at 10 45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

..... (duration) ..... yrs. 9 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? — 7

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) Chas. R. Goldsborough, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
WESTERN	October 1920
20 UNDERTAKER	ADDRESS
JOHN F. DENNY	715 LIGHT ST.

Spec. 6-9-19—H. P. Co.—1000 Bks.

1046938 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046938

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 105 Old Harford Road ST. Hamilton WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Wagmuth

(a) RESIDENCE. No. 6105 Old Harford ST. Hamilton WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND (or) WIFE of Frederick Wagmuth

6 DATE OF BIRTH (month, day, and year) March 22 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Manchester Maryland

PARENTS

10 NAME OF FATHER Henry Gettier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown Unknown

14 Informant (Address) Mrs G. C. Leinbach 105 Old Harford Road Hamilton

15 Filed SEP 30 1920 ROBERT E. LEAUTER Registrar Burial Permit Clerk

TION is very important. See instructions on

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1920

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1919, to Sept 29 1920

that I last saw h.. alive on Sept 28 1920

and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Debility

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. C. Lowe, M. D.

, 19 (Address) 27 Harford Rd Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park Cemetery	Oct 1 1920
20 UNDERTAKER Fred K. Lassahn & Sons	ADDRESS Fallstaff

2046939 HEALTH DEPARTMENT—CITY OF BALTIMORE 2046939

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin St Hospital St.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Knurth

(Residence in Baltimore: No. 222 N 1st St Brooklyn md St.; 4yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word)
Male	white	Single

6-DATE OF BIRTH, April (Month) 6 (Day), 1913 (Year)

7-AGE, 7 yrs. 5 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Julius Kurth

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Sadie C. Branigan

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Kurth

(Address) 222 N. First st.

15- ROBERT B SLAUTER

Filed SEP 30 1920 191.... Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Chas death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tetanus

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Burn in foot

(Duration) ....yrs. ....mos. 10 ds.

(Signed) John A. McHenry M. D.
(Coroner)

Sept 29 1920 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Brooklyn

Former or usual residence 222 N 1st St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem	Oct 1, 1920
20-UNDERTAKER	ADDRESS
F. A. Krauss & Son	703 Hanover St

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

046940 92-D 046940

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 S. Wolf ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeanette Bush

(Residence in Baltimore: No. 320 S. Wolf St.; 1 yrs., 3 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, June (Month) 16 (Day), 1919 (Year)

7-AGE, 1 yrs. 3 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Felix Bush

11-BIRTHPLACE OF FATHER (State or Country), Chicago

12-MAIDEN NAME OF MOTHER Lillie Schroeder

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Felix Bush

(Address) 320 S. Wolf St.

15-

SEP 30 1920

Filed....., 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 29 (Month) (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1920, to Sept 29 1920, that I saw h[illegible] alive on Sept 29 1920, and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) .....yrs. .....mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) .....yrs. .....mos. 10 ds.

(Signed) [illegible] M. D.

9-29, 1920. (Address) 722 S. Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary Cemetery Rd. DATE OF BURIAL, Sep. 31., 1920.

20-UNDERTAKER Wendell Duffy & Son ADDRESS 37 S Ann

Important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

046941 HEALTH DEPARTMENT—CITY OF BALTIMORE 046941

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 Jefferson ST.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Yaeger

(a) RESIDENCE. No. 2108 Jefferson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Yaeger

6 DATE OF BIRTH (month, day, and year) Unknown 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant (Address) Anna Yaeger 2108 Jefferson

15 Filed ..... 19 ..... Registrar

SEP 30 1920 Robert F. Morrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 25 1920, to Sept 28 1920, that I last saw him alive on Sept 28 1920, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Progressive Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Loos M. D.

9/29, 1920 (Address) 413 N Fremington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct 2 1920
20 UNDERTAKER	ADDRESS
Wendell Disfel & Son	378 Mn

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 46942

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 46942

92-051

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Eusebia

(a) RESIDENCE. No. St. Francis Convent ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
39				

8 OCCUPATION OF DECEASED 165

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10 NAME OF FATHER John Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kansas

12 MAIDEN NAME OF MOTHER Annie Ford.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kansas

14 Informant Mother Margaret Mary (Address) St. Francis Convent E. Chase St. Baltimore

15 Filed ..... 19.. Registrar

OCT 3 0 1920

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1920, to Sept. 29, 1920, that I last saw her alive on Sept 29, 1920, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ....yrs. ....mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept. 23

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs

(Signed) J. B. Bronaugh, M. D.

9-30, 1920 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Oct. 1920
20 UNDERTAKER	ADDRESS
Felix B. Pyc	100 E. Fulton St

CAUSE OF DEATH. See instructions on back of this certificate. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46943. HEALTH DEPARTMENT—CITY OF BALTIMORE D46943.

105 V

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 512 Warner ST.: 7V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Brown

(a) RESIDENCE. No. 512 Warner ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	C.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Elija Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Fronie Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del.

14 Informant E. Brown.
(Address) 512 Warner

15 Filed OCT 1 - 1920 ROBERT B. KRAUTER Registrar

TION is very important. See instructions on back of Certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 20. 1920. to Sept 29. 1920. that I last saw h in alive on Sept 27. 1920. and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Gasho-enteritis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Wesley Hoag M. D.

9/30 1920 (Address) 729 Eutaw & Lem

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn St	Oct 1st 1920
20 UNDERTAKER	ADDRESS
L. L. Brown & Son	101 W. Monty St

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046944

HEALTH DEPARTMENT—CITY OF BALTIMORE

1046944

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 739 Dover ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Jackson

(a) RESIDENCE. No. 739 Dover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State) Virginia

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 25, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) (Building)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Maryland

PARENTS

10 NAME OF FATHER James J. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland.

12 MAIDEN NAME OF MOTHER Mary L. Briscoe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co, Maryland.

14 Informant George Hoddard

(Address) 519 S. Green

15 Filed ..... 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept, 2, 1920, to Sept, 29, 1920, that I last saw him alive on Sept, 26, 1920, and that death occurred, on the date stated above, at 10.15a m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum negative

(Signed) David Scrandrett, M. D.

9/30, 1920 (Address) 122 W Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cove Point Md Calvert Co

DATE OF BURIAL: Oct 2 1920

20 UNDERTAKER: L. B. Brown and Son

ADDRESS: 1118 W. Monty St

CAUSE OF DEATH TO BE CERTIFIED ON BACK OF CERTIFICATE. See instructions on back of this certificate. ATTENTION is very important.

M. D. Dd V Worked street car & Pier 2 Railway

Zoa Elizabeth Hogarty

D46945 HEALTH DEPARTMENT—CITY OF BALTIMORE D46945

CERTIFICATE OF DEATH. X 156

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Jackson's Wht. Foot of Broadway ST.; WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Z. E. Hogarty.

(Residence in Baltimore: No. Y. W. C. A. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... (Month) ....., 1 ..... (Day) (Year)

7-AGE, about 35 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Saleswoman
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) New York State

PARENTS.

10-NAME OF FATHER, James Hogarty

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Jennie Sweeney

13-BIRTHPLACE OF MOTHER (State or Country), New York State

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Hogarty

(Address) 225 Forrest St W W

15- Undertaker

Filed ..... 191.....

Registrar.

OCT 1 - 1920

ROBERT P. LAMOTTE
Burial Permit Clerk

CAUSE OF DEATH to be filled in plain words. Indefinite answers will not be accepted. Every question must be answered if possible. Omissions will cause delay and may be important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 9 (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide Drowning

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Blades M. D.
(Coroner)

9/30/20, 191... (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Carmel Cemetery	10/1/20

20-UNDERTAKER	ADDRESS
Wm J Buchanan & Son	Balto & Pine

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46946

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46946

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. 824 ~~N. Washington~~ ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosemary Slifker

(a) RESIDENCE. NO. 824 N. Washington ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Aug. 24 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John A. Slifker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Helen A McDaigle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John A. Slifker

(Address) No. 824 N Washington St

15 Filed OCT 1 - 1920 19 ROBERT J. BRAMBLE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1920

17 I HEREBY CERTIFY, That I attended deceased from 9/19/20 . 19 . to 9/30/20. 19 .

that I last saw her alive on 9/30/20 . 19 .

and that death occurred, on the date stated above, at 1:50 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) E. P. Greenawalt, M. D.

. 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct. 1st 1920
20 UNDERTAKER Henry Hosch & Son	ADDRESS 1301 E Eager

TION is very important. See instructions on back.

1046947 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046947

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1043 Shields alley ST.: 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Gray

(Residence in Baltimore: No. 1043 Shields alley St.; 46 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	single

6-DATE OF BIRTH, unknown, 1874
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
46 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Delivery man
(b) General nature of industry, business, or establishment in which employed (or employer): meats

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Jennie Phillips

(Address) 1726 Druid Hill Ave.

15-

Filed OCT 1 - 1920, 191.....

ROBERT E KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 28, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pyaemia Lung Abscess

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) yrs. mos. ds.

(Signed) J. A. Helmuth M. D.
(Coroner.)

Sept. 29 1920 (Address) 2802 Edgewood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Oct 1, 1920

20-UNDERTAKER John H Treadwell ADDRESS 142 [illegible]

CAUSE OF DEATH must be plainly written. Every item important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46948 HEALTH DEPARTMENT—CITY OF BALTIMORE D46948

CERTIFICATE OF DEATH. 28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2044 W Cvrs ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eloise Fields

(a) RESIDENCE. NO. 2044 W Cvrs ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unoccupied 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ga.

PARENTS

10 NAME OF FATHER Geo Fields

11 BIRTHPLACE OF FATHER (city or town) (State or country) California

12 MAIDEN NAME OF MOTHER Silsie Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant (Address) Geo. Fields 204 W Cvrs St

15 Filed OCT 1 - 1920 ROBERT B KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30th 1920

17 I HEREBY CERTIFY, That I attended deceased from 8/14/20, to 9/30/20, that I last saw her alive on 9/28/20, and that death occurred, on the date stated above, at 5.40 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema & Congestion. (Probably TBC) (duration) 8/14/20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Infantile Paralysis from birth (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Gunbarley, M. D.

10/1/20, 19 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Oct 3 1920

20 UNDERTAKER John M. Frazier

ADDRESS 142 W Hill St

CAUSE OF DEATH in plain terms, so that it may be classified. See back of certificates. TION is very important. See instructions on back of

...c.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 46949 — 40-D 46949

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) St Joseph Hospital ST.: (WARD)

2-FULL NAME Margaretta Ruth.

(a) RESIDENCE. NO. 1500 N. Washington ST.. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F
4 COLOR OR RACE: W
5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Ruth.

6 DATE OF BIRTH (month, day, and year) Jan 16th 1883
7 AGE Years 37 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER George Shafer
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore
12 MAIDEN NAME OF MOTHER Catherine Klein
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Charles G. Ruth 1500 N. Washington St

15 Filed OCT 1 - 1920 ROBERT F. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 28th, 1920, that I last saw her alive on Sept 29th, 1920, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows: Myocardial insufficiency.

CONTRIBUTORY (Secondary) Anemia (duration) yrs. mos. ds. Organs (duration) About 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Microscopic

(Signed) J. Scheeren M. D.
(Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lauden Park
DATE OF BURIAL Oct 1 1920
20 UNDERTAKER Frank A. Fink
ADDRESS 415 N. Gay

D46950

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46950

CERTIFICATE OF DEATH.

X 172

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Thomas

(Residence in Baltimore: No. 837 Courtland St.

adv. 14 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH August – 1873
(Month) (Day) (Year)

7-AGE, 47 yrs. 1 mos. – ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Conveyancer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.
10-NAME OF FATHER, Thos J Thomas
11-BIRTHPLACE OF FATHER (State or Country), Pa.
12-MAIDEN NAME OF MOTHER Susanna Yoe
13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jno. Thomas
(Address) Tempest Pa

15-
Filed....., 191.....
Registrar.

CAUSE OF DEATH in plain terms. ... important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull, Accident

(Duration), yrs. mos. 6 hrs.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) Jos Guthrie Slade M. D.
(Coroner.)

9/30, 21, 191.. (Address) 1443 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Duncannon Pa.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Duncannon Pa	10/1/20 19....

20-UNDERTAKER John J Lahey & Sons ADDRESS 1318 Light St

OCT 1 – 1920 ROBERT E KRAUTER Burial Permit

Traffey

HEALTH DEPARTMENT CITY OF BALTIMORE

143489
D 46952

CERTIFICATE OF DEATH.

111

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabel Traffey.

(a) RESIDENCE. NO. 371 St. Helena Road, ST., 12th WARD.
(Usual place of abode)

Length of residence in city or town where death occurred - Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F. Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Traffey

6 DATE OF BIRTH (month, day, and year) Sept 25 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER William C. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Serina Gleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant J. H. H.
(Address)

15 Filed OCT 1 - 1920 19 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1920, to Sept 29, 1920, that I last saw her alive on Sept 29, 1920 and that death occurred, on the date stated above, at 9:25 a. m.

The CAUSE OF DEATH* was as follows:

acute yellow atrophy of liver 2

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. R. Mason M. D.

, 19 (Address) John Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Oct 2 1920

ADDRESS 2008 Reisters

20 UNDERTAKER J. Hervig & Co

TION is very important. See instructions on back.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46952 — 1920 — 46952

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 805 S. Paca st ST.; 21 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Ahaus

(a) RESIDENCE. NO. 805 S. Paca st ST.. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 67 yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: white
5 ~~Single, Married, Widowed,~~ or ~~Divorced (write the word)~~: Widow
5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Frederick Ahaus
6 DATE OF BIRTH (month, day, and year): June 27 1853
7 AGE: Years 67 Months 3 Days 3 If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9 BIRTHPLACE (city or town) (State or country)

PARENTS
10 NAME OF FATHER: Frederick Schumann
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germy
12 MAIDEN NAME OF MOTHER: Christina Schuetz
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germy

14 Informant (Address): Sophia Ahaus 805 S. Paca st
15 Filed OCT 1 1920, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 30 19 20.
17 I HEREBY CERTIFY, That I attended deceased from Feb 1 19 20, to Sept 30 19 20, that I last saw h[illegible] alive on Sept 30 19 20, and that death occurred, on the date stated above, at 6 p m.
The CAUSE OF DEATH* was as follows:

Mitral Regurgitation 7 yrs.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
What test confirmed diagnosis?
Was there an autopsy?

(Signed) Henry Boyd M. D.
19— (Address) 62 Columbus

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Oct 2 1920
20 UNDERTAKER: Jos Joerdens & Son — ADDRESS: 217 S. Paca

ROBERT J. BRAUTIGAM
Burial Permit Clerk

See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1900 Bks.

Heinrich

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 46953

CERTIFICATE OF DEATH.

1202 D 46953

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1822 N. Milton Ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernst H. Heinrich

(a) RESIDENCE. No. 1822 N. Milton Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louis Heinrich

6 DATE OF BIRTH (month, day, and year) Oct. 10 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Selkin Bros

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Lost Knowledge

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Lost Knowledge

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Annie Heinrichs
(Address) 1822 N Milton Ave

15 Filed OCT 1 - 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 1 1920

17 I HEREBY CERTIFY, That I attended deceased from June 5th, 1920, to October 1st, 1920, that I last saw him alive on October 1st, 1920, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonitis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory & Am. clinic

(Signed) Albert E Singenstag, M. D.

10/1, 1920 (Address) 1613 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bonnie Cliff	Oct 4 1920
20 UNDERTAKER	ADDRESS
J Herzog & Co	2008 Eutaw

CAUSE OF DEATH. ATTENTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 46954 HEALTH DEPARTMENT—CITY OF BALTIMORE D 46954

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 S Regester ST.: V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee Lewandoski

(a) RESIDENCE. NO. 722 S Regester ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Infant

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of ———

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ... min.
		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Joseph J Lewandoski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Eva DeMartino

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Joseph Lewandoski
(Address) 722 S Regester

15 OCT 1 - 1920 ROBERT E CRAWFORD Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1920, to Sept 17, 1920, that I last saw h alive on Sept 17, 1920, and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH* was as follows:

Congenital Weakness
(Immediate)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Jaundice

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Thomas, M. D.

Sept 17, 1920 (Address) 16 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary Cappe Rd	Sept 17 1920
20 UNDERTAKER Wendell Bippel & Son	ADDRESS 378 Mon

CAUSE OF DEATH in plain terms, ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D46955 D46955

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D46955

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3520 Frederick Ave. ST.; 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J. Schaeffer, Sr.

(a) RESIDENCE. No. 3520 Frederick Ave. ST., 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella A. Schaeffer

6 DATE OF BIRTH (month, day, and year) Feb. 14 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marble work

(b) General nature of industry, business, or establishment in which employed (or employer) 076

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Michael Schaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret L——

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Ella A. Schaeffer

(Address) 3520 Frederick Ave

15 Filed OCT 1 - 1920 ROBERT B. KRANTZ, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29, 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug. 1919, to Sept 29. 1920.

that I last saw h— alive on Sept 28, 1920,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus.
Ch. pneumonia tuberculosis.
Arteriosclerosis.

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Edward Vanderbeck, M. D.

, 19 (Address) 1411 Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Oct 2, 1920
20 UNDERTAKER Horace Burgee & Son	ADDRESS 3621 Falls Rd

CAUSE OF DEATH in plain terms, so that it may be readily understood by physicians and others. Abbreviations of certificates. TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L046956 L046956

CERTIFICATE OF DEATH.

X91 REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1918 Mosher ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Julia Belvin -

(Residence in Baltimore: No. 1918 Mosher - St.; ..... yrs., 2 mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED~~, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 29 (Day), 1917 (Year)

7-AGE, 3 yrs. 2 mos. 1 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... ONO
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Va -

PARENTS.

10-NAME OF FATHER. Wm Thomas Belvin

11-BIRTHPLACE OF FATHER (State or Country). Va -

12-MAIDEN NAME OF MOTHER Rosetta Wallace

13-BIRTHPLACE OF MOTHER (State or Country). Va -

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm T Belvin

(Address) 1918 Mosher St

15- OCT 1 - 1920 ROBERT E KLAUTER

Filed ..... 191 ..... Burial Permit Registrar

CAUSE OF DEATH must be given. Items are important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 26 1920. to Sept 30 1920, that I saw h.. alive on Sept 30 1920, and that death occurred, on the date stated above, at 9.0 a. m.

The CAUSE OF DEATH* was as follows:

Bronchi- Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Streptococcus Throat

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. W. King M. D.

9-21, 1920 (Address) 1821 W Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Norfolk Virginia

19-PLACE OF BURIAL OR REMOVAL, Norfolk Va — DATE OF BURIAL, Oct 1 1920.

20-UNDERTAKER Richard Gore — ADDRESS 1723 W Lafayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

046957

HEALTH DEPARTMENT—CITY OF BALTIMORE

046957

104

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 Harford Road ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis O. Bauereis

(a) RESIDENCE. NO. 930 E. Eager ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 4 mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 8th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis Bauereis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Marie A. Schlag

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Louis Bauereis (Address) 930 E. Eager St.

15 Filed OCT 1 - 1920 19.. ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29th 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 21 1920 to Sept 29 1920, that I last saw h alive on Sept 29 1920, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(Summer Diarrhea)

(duration) yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 930 E Eager St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John Ruhrah, M. D.

Sept 29 1920 (Address) 11 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 1. 1920

20 UNDERTAKER Mr. & Mrs. John H. Deufel. ADDRESS 801 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be understood by the general public. Omissions will delay registration. Be sure to answer every question. Do not write on back of certificates. TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46958

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46958

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1117 W Mulberry ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugenia C Clements

(a) RESIDENCE. No. 1117 W Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Francis E Clements

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hous wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Jone E Tonney

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Frederick

12 MAIDEN NAME OF MOTHER Mary Mason

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Francis E Tonney
(Address) 8411 Beechcroft

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 7 1920 to Sept 29 1920
that I last saw her alive on Sept 28 1920
and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

(duration) ? yrs. 1½ mos. ? ds.

CONTRIBUTORY (Secondary) Nephritis Gastritis

Chronic (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ?

(Signed) J Allen Williams M. D.

, 19 (Address) 611 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Oct 2 19
20 UNDERTAKER	ADDRESS
Robt J Turner & Son	Waverly

mation should be carefully written in ink, so that it may be properly
CAUSE OF DEATH in plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46959

CERTIFICATE OF DEATH.

126

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 West Barre ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Michel

(a) RESIDENCE. NO. 919 W Barre ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 8 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or ~~WIFE of~~) Magdaline Michel

6 DATE OF BIRTH (month, day, and year) 10. 2. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	8.	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Carpenter

(b) General nature of Industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John A Michel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Barbara Bach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Magdalina Michel
(Address) 919 W Barre St

15 Filed OCT. 1 1920 ROBERT B. ARTHUR Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to Sept 28, 1920, that I last saw him alive on Sept 28, 1920, and that death occurred, on the date stated above, at 12:20 P. m.

The CAUSE OF DEATH* was as follows:

a Cerebral Hemorrhage
(Primary)
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 8-16-20

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) G. E. Gurton, M. D.

9. 29. 1920 (Address) 204 E Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemtry	Oct 2d 1920
20 UNDERTAKER	ADDRESS
Leo Leimbach & Son	647 W Baltimore St

CAUSE OF DEATH. See instructions on back of CERTIFICATE. IMPORTANT. This information is very important.

over

D46960

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46960

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Maryland Gen. Hosp., ST.: 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia M. Hutchins

(Residence in Baltimore: No. 1231 Mt. Royal Ave. St.: 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, November 15, 1879 (Month) (Day) (Year)

7-AGE, 41 yrs. 10 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Washington, D.C.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...Robt. W. Hutchins...

(Address)...1231 Mt. Royal Ave...

15-

Filed OCT 2 1920, 191.... Registrar.

BOBERT D. BRADFORD
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 28, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Aut. (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide??
Arsenous poison??
Subject to stomach analysis
(Duration)....yrs....mos. 1 ds.

CONTRIBUTORY (Secondary)
(Duration)....yrs....mos....ds.

(Signed) J. D. Hennessy M. D. (Coroner.)

Oct. 1, 1920 (Address) 2802 E. Monument Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death md. Gen. Hosp. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? 1231 Mt. Royal Ave.

Former or usual residence Same.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Oct. 1, 1920
20-UNDERTAKER	ADDRESS
Robert Brookes	Calhoun

over

N. B.—Every item of information should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Omit abbreviations. Name important. See instructions on back of certificate.

Final decision suicide

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning: Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D46961

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D46961

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 Garrison Lane ST.: W WARD)

2-FULL NAME Regina Krys.

(a) RESIDENCE. No. 307 Garrison Lane ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ~~mos.~~ ~~ds.~~ How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) June 3rd 1851 June 3, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Bessie Cleffler

(Address) 307 Garrison Lane

15 Filed OCT 1 - 1920 ROBERT B. LAZENBY Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to Sept 29, 1920, that I last saw h[er] alive on Sept 29, 1920, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Goiter, Sclerosis, Septicity, Nephritis, Cardiac Dilatation

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

2 days yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Norbert C Entach, M. D.

10/1, 1920 (Address) 215 Walbrook Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cemetery Hampden	Oct 1st 1920
20 UNDERTAKER	ADDRESS 2101
George L Schwabt Bro	Frederick Ave

CAUSE OF DEATH in plain terms, ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D46962

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46962

CERTIFICATE OF DEATH.

151

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 Vincent ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Mrs~~ Elizabeth Brown

(Residence in Baltimore: No. Life 222 N Vincent St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Blk	Single

6-DATE OF BIRTH. Oct (Month) 22 (Day), 1919 (Year)

7-AGE, 11 yrs. 11 mos. 8 ds. | If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... X 0D
(b) General nature of industry, business, or establishment in which employed (or employer)..... X .....

9-BIRTHPLACE, (State or Country), Balto City Md

PARENTS.

10-NAME OF FATHER, Roger Brown

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Cora Bennett

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Roger Brown

(Address) 222 Vincent St

15- OCT 1 - 1920 Filed....., 191..... ROBERT E KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 29th (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1920, to Sept 29 1920, that I saw her alive on Sept 29 1920, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Marasmus

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration).....yrs.....mos.....ds.

(Signed) John E Granger M. D.

....., 191... (Address) 1002 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Druid Hill | DATE OF BURIAL, Oct 1, 1920

20-UNDERTAKER Daniel Easter | ADDRESS 916 Pennsylvania

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

046963 HEALTH DEPARTMENT—CITY OF BALTIMORE 046963

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 939 Bond Ave. ST.; 18 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME Alice A. Dueck

(Residence in Baltimore: No. 939 Bond Ave St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Cl

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1889 (Year)

7-AGE, 31 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Agent 041
(b) General nature of industry, business, or establishment in which employed (or employer) Laundry

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Eaton

(Address) 916 Penna Ave

15- Filed OCT 1 - 1920, 191.... ROBERT B KRAUTER Register.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 20, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1920, to Sept 30 1920, that I saw h[illegible] alive on Sept 30 1920, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Pulmo Embolism

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. D. Hackett M. D.

9/30/20 191.... (Address) 1107 N Calvert

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, Oct 2, 1920

20-UNDERTAKER David Eaton

ADDRESS 916 Penna Ave

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46964

CERTIFICATE OF DEATH.

D46964.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5134 Park Heights Av ST.; 27 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Rosenberg

(Residence in Baltimore: No. 5134 Pk Heights Av St.; 80 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, May (Month) 15 (Day), 1841 (Year)

7-AGE, 79 yrs. 4 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mom None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Abraham Rosenstock

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER — Tannenbaum

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo J Abraham

(Address) Norwood Apts

15- ROBERT J. BRAUTER Clerk

Filed....., 191.... Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Certificate incomplete unless all important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 12 1920, to Sept 30 1920, that I saw h[er] alive on Sept 30 1920, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Valvular Lesions of Heart

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute edema of Lung

(Duration) yrs. mos. ds.

(Signed) W D Love M. D.

Sept 30, 1920 (Address) 836 W North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pikesville Hebrew — DATE OF BURIAL, Oct 3rd, 1920

20-UNDERTAKER Harris Sondheim — ADDRESS 1818 Mt Royal Ave

Spec.—8-24-14—M. & T.—2000 Bks.

1046965 HEALTH DEPARTMENT—CITY OF BALTIMORE 1046965

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1354 Reynolds ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph A. Brigerman

(Residence in Baltimore: No. 350 Reynolds St.; 38 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May (Month) ..... (Day), 1882 (Year)

7-AGE,	If LESS than 1 day,
38 yrs. 4 mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Longshoreman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Geo Brigerman

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Do Not Know

13-BIRTHPLACE OF MOTHER (State or Country), Geo. not Given.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Brigerman

(Address) 1354 Reynolds St

15- Filed OCT 1 - 1920, 191..... ROBERT E KRAUTER BURIAL PERMIT Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1920, to Sept 29 1920, that I saw him alive on Sept 28th 1920, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

..... Pulmonary Tuberculosis

.....

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..., ... yrs. ..... mos. ..... ds.

(Signed) T. A. Shepard M. D.

10-1-, 1920 (Address) 423 E Fay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Cedar Hill Cem	Oct 2, 1920
20-UNDERTAKER	**ADDRESS**
John F Haley & Bro	318 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Be important. See instructions on back of certificate.

D. 46966

HEALTH DEPARTMENT--CITY OF BALTIMORE

D. 46966

CERTIFICATE OF DEATH

80

1 PLACE OF DEATH 1908 Eutaw St. REGISTERED NO. C .....

CITY OF BALTIMORE (No. ..... ST. 16 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas W. Ruddach

(Residence in Baltimore: No. 1024 Brantly Ave If not in Baltimore give usual residence) Age 70 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male | 4-COLOR OR RACE White | 5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Married

6-DATE OF BIRTH Sept. 25, 1850 (Month) (Day) (Year)

7-AGE 70 yrs. — mos. 5 ds. | If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R.

9-BIRTHPLACE (State or country) Balto. Md.

PARENTS

10-NAME OF FATHER Washington Ruddach

11-BIRTHPLACE OF FATHER (State or country) Balto Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Etta S. Ruddach

(Address) 1024 Brantly Ave

15. Filed OCT 1 - 1920 191 Robert P. Harrison, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept. 30, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11 A.M. Sept 30, 1920 to 5 P.M. Sept 30 1920.
that I saw him alive on Sept. 30 1920
and that death occurred, on the date stated above, at 5:20 P.M.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... yrs. ..... mos. 4 ds

Contributory (SECONDARY) Arterial sclerosis

(Duration) 5 yrs. + mos. ..... ds.

(Signed) Durand Purnell Price M. D.

Oct. 1, 1920 (Address) 1030 Franklin St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Loudon Park | DATE OF BURIAL Oct 2 1920

20-UNDERTAKER Geo R. Little | ADDRESS 531 Fremont

N. B.-Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 46967 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46967

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 184

CITY OF BALTIMORE (No. Md. Gen. Hosp. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Brown

(Residence in Baltimore: No. 1521 N. Stricker St. St.; 56 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, Nov. 4, 1864 (Month) (Day) (Year)

7-AGE	If LESS than 1 day, ...hrs. or.....min.?
55 yrs. 10 mos. 30 ds.	

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Street paver,
(b) General nature of industry, business, or establishment in which employed (or employer): 077

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Alfred Brown.

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Louise Hilton

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Brown

(Address) 714 N. Fayette St.

15-

Filed ....., 191.....

Registrar.

OCT 1 1920

Robert P. Harrison,
Burial Permit Clerk.

N. B.—Every item of information must be given. Be careful to see that each item is properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 30, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull by blow of an assault by a negro

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. D. Hennessy M. D. (Coroner.)

Oct. 1, 1920 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Md. Gen. Hosp. In the of death.....yrs.....mos. 1 ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Penna. Ave & Baker St.

Former or usual residence 1521 N. Stricker St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park,	Oct. 2, 1920
20-UNDERTAKER George J. Smith	ADDRESS 714 W. Fayette St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46968 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46968

CERTIFICATE OF DEATH. 78

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (Municipal Tuberculosis Hospital ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Bisco

(a) RESIDENCE. No. 1113 Vincent st. ST., WARD. Lifetime.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 04

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Philip Bisco

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records (Address): M. T. Harrison.

15 Filed OCT 1 1920 Robert P. Poe, Registrar. 19 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1920, to Sept. 29, 1920, that I last saw him alive on Sept. , 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 (?) mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum

(Signed) L. J. Gregory M. D.

9-29-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 3 1920
20 UNDERTAKER	ADDRESS
Edw. Ringgold	1463 N. Ca[illegible]

mation should be carefully supplied. Any CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46969 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46969

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 227 S Bollington ave. WARD 1)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Blum

(a) RESIDENCE. No. 227 S Bollington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 9 mos. 25 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Michael Blum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Garmas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Michael Blum 227 S Bollington

Filed OCT 1 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1920, to Sept 30, 1920, that I last saw him alive on Sept 29, 1920, and that death occurred, on the date stated above, at 4:45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB
tuberculosis

(duration) about 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Geo Keller, M. D.

Oct. 1, 1920 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Oct 2 1920

20 UNDERTAKER Wendell Dippel's Son

ADDRESS 3737 Fleet Ave

Information should be carefully supplied. Exact statement of facts required. Each item should be properly classified. Exact statement of facts required. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of facts required. TION is very important. See instructions on back of certificates.

D.46970 HEALTH DEPARTMENT---CITY OF BALTIMORE D.46970

CERTIFICATE OF DEATH

Registered No. C 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 N. Bond St.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Welsh.

(Residence in Baltimore: No. 1714 N. Bond St.; 75 yrs. 3 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widowed

6-DATE OF BIRTH June (Month) 10 (Day) 1845 (Year)

7-AGE 75 yrs. 3 mos. 20 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: House wife.
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE (State or country) Baltimore Md.

PARENTS

10-NAME OF FATHER William Linick

11-BIRTHPLACE OF FATHER (State or country) Va.

12-MAIDEN NAME OF MOTHER Maria Leach

13-BIRTHPLACE OF MOTHER (State or country) Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jas. W. Welsh

(Address) 1714 N Bond

15- Filed OCT 1 - 1920 191 Robert P. Harrison, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept (Month) 30 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 - 1920, to, Sept 20 - 1920, that I saw h-er alive on Sept 29 - 1920, and that death occurred, on the date stated above, at 0.30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration) yrs 4 mos ds.

Contributory (SECONDARY)

(Duration) yrs mos ds.

(Signed) E. Gill Hall M. D.

Sept 30 - 1920. [Address] 617 E. North Ave.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 4, 1920

20-UNDERTAKER	ADDRESS
G. F. Russell & Son	2620 St Paul St.

N. B.—Every item of information should be carefully supplied. Any item may be properly classified. Exact statement of DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificate.

D.46971

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46971

175-001

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. F. Isodr Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Madeline Lidard

(Residence in Baltimore: No. 2075 E 31st St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April (Month) 12th (Day), 1916 (Year)

7-AGE, 4 yrs. 5 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....—
(b) General nature of industry, business, or establishment in which employed (or employer).....—

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Edgar Lidard

11-BIRTHPLACE OF FATHER (State or Country). Balto Md.

12-MAIDEN NAME OF MOTHER Elizabeth Hess

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar Lidard

(Address) 2075 E. 31st St.

15- Robert P. Harrison,

Filed OCT 1 1920, 191.....

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) 29 (Day), 1916 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to DX death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto Accident

Fracture of Skull

(Duration) ....yrs. mos. 2 hrs ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ....yrs. mos. 5 hrs ds.

(Signed) Geo A Blake M. D.

(Coroner.)

9 30 1916 (Address) 3 W Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oaklawn Cemetery

DATE OF BURIAL, Oct 2nd, 1920

20-UNDERTAKER E. C. Fanning & Son

ADDRESS 1938 E Lafayette Ave

N.B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46972 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46972

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1712 Poplar Grove St ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel M Channell.

(a) RESIDENCE. No. 1712 Poplar Grove St ST., 15 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 5 mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Patrick J Channell

6 DATE OF BIRTH (month, day, and year): July 9- 1899

7 AGE: 21 Years | Months 2 | Days 21 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Huttonsville W. Va.

PARENTS

10 NAME OF FATHER: John M Facey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Huttonsville W. Va

12 MAIDEN NAME OF MOTHER: Ettie White

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Huttonsville W Va

14 Informant: Lloyd L Powell

(Address): 3501 Allendale Road

15 Filed ... 19 ... Robert T. Harrison, Registrar

Burial Permit Clerk.

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 30 19 20

17 I HEREBY CERTIFY, That I attended deceased from Sept. 8, 19 20, to Sept 30, 19 20, that I last saw h[illegible] alive on Sept 30, 19 20, and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) ... yrs. 7 mos. ... ds.

CONTRIBUTORY (Secondary) Accidents

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..., M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL: Oct 2- 19 20

20 UNDERTAKER: William Cook

ADDRESS: 5022 North Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46973 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46973

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4101 Lloyd Ave ST.: 78 Howard Park WARD)

2-FULL NAME Henrietta Ebaugh

(a) RESIDENCE. No. 4101 Lloyd ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of James M Ebaugh

6 DATE OF BIRTH (month, day, and year) Sept 25 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Capt Robt Brooke

11 BIRTHPLACE OF FATHER (city or town) Wash Dc
(State or country)

12 MAIDEN NAME OF MOTHER ~~Mount Hope~~ Mary Hope

13 BIRTHPLACE OF MOTHER (city or town) Mount Hope
(State or country)

14 Informant James M. Ebaugh
(Address) 4101 Lloyd ave

15 Filed OCT 1 - 1920 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1st 1920

17 I HEREBY CERTIFY, That I attended deceased from June, 19 18, to Oct 1st, 19 20, that I last saw her alive on Sept 30th, 19 20, and that death occurred, on the date stated above, at 1 1/2 a m.

The CAUSE OF DEATH* was as follows:

Fibrilation of Heart

(duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Intern Consult & Self

(Signed) A. C. Bunnell M. D.

(Address) 4309 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	Oct 4 1920
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Fayette

REGISTRAR SHOULD BE CAREFUL to write in plain terms, so that it may be properly examined. CAUSE OF DEATH in plain terms, so that it may be properly examined. TION is very important. See instructions on back of certificates.

D.46974 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46974

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — CITY OF BALTIMORE (No. 9-E Pleasant St.; 4 Ward); 120 Registered No. C

2-FULL NAME — Maud M. Conkey

(Residence in Baltimore: No. 9-E Pleasant St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

35.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female.

4-COLOR OR RACE: W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Married

6-DATE OF BIRTH: Dont know; (Month) (Day); 1866 (Year)

7-AGE: 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: at Home. (b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): England.

PARENTS.

10-NAME OF FATHER: Dont Know

11-BIRTHPLACE OF FATHER (State or Country): Dont know.

12-MAIDEN NAME OF MOTHER: Dont know.

13-BIRTHPLACE OF MOTHER (State or Country): Dont know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Percival Grant

(Address): 9 E Pleasant

15- Robert P. Harrison, Burial Permit Clerk. Registrar.

Filed OCT 1 1920, 191

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: 9 30, 1914. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(Duration) 6 mos. 14 ds.

CONTRIBUTORY (Secondary): Cardiac Disease

(Duration) yrs. mos. 1 ds.

(Signed) Geo. C. Staples M. D. (Coroner.)

9 30 1914 (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Trinity Cem. DATE OF BURIAL: Oct 2 1914

20-UNDERTAKER: Wm Cook. ADDRESS: 522 E. North Ave

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.46975 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46975

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 237 S. Collington Ave. St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Roland Warren Jr

(a) RESIDENCE. No. 237 S. Collington Ave WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 23 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Chas. R. Warren

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Edna S. Griffner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Chas. R. Warren

(Address) 237 S. Collington Ave

15 Filed OCT 1 - 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 17, 1920, to Sept 30, 1920,

that I last saw him alive on Sept 30, 1920,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ... yrs. ... mos. 13 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Cook, M. D.

10/1, 1920 (Address) 413 N. Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION~~ OR REMOVAL	DATE OF BURIAL
Oaklawn Cem	Oct 2 1920
20 UNDERTAKER	ADDRESS
Wm J Ecker & Sons	N. Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Fam... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 46976 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 46976

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 Andre. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Czeslawa Lanczynska

(a) RESIDENCE. No. 1406 Andre ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 8 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Whit

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan. 26, 1920

7 AGE — Years: — Months: 8 Days: 3 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): " "

(c) Name of employer: " "

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Stefan Lanczynski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Julia Gonsiorowka

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Stefan Lanczynski

(Address): 1406 Andre

15 Filed ... 19 ... Robert P. Harrison, Registrar

OCT 2 - 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1920, to Sept. 30, 1920, that I last saw her alive on Sept 30, 1920, and that death occurred, on the date stated above, at 8. 0. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. J. Scahey, M. D.

Oct. 1 1920 (Address) 638 First Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Oct. 1 1920

20 UNDERTAKER: Wm Fiallkowski — ADDRESS: 1618 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D.46977 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46977

CERTIFICATE OF DEATH. REGISTERED No. C

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE (No. 23 St., 23 Ward)

2-FULL NAME Annie Allen.

(Residence in Baltimore: No. 256 E. Randall St

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write word) Single

6-DATE OF BIRTH, Aug 7 (Month) (Day), 1903 (Year)

7-AGE. 17 yrs. 1 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Columbia
(b) General nature of industry, business, or establishment in which employed (or employer) Bag Co.

9-BIRTHPLACE, (State or Country) Colored Co. Md.

PARENTS.

10-NAME OF FATHER, John T. Allen

11-BIRTHPLACE OF FATHER (State or Country) Calvert Co. Md

12-MAIDEN NAME OF MOTHER Mollie Ridgly

13-BIRTHPLACE OF MOTHER (State or Country) Calvert Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John T. Allen

(Address) Calvert Co. Md

15- Robert P. Harrison,

Filed OCT 2 - 1920, 191 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9 (Month) / 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull accident (Duration) yrs. mos. 2 hrs.

CONTRIBUTORY (Secondary) Shock. (Duration) yrs. mos. 1 hr.

(Signed) Geo Edwin Bladd M. D. (Coroner)

10/1/ 191... (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Cove Point, Calvert Co. Md

19-PLACE OF BURIAL OR REMOVAL, Calvert Co. Md

DATE OF BURIAL, 10/ 3/, 19 20

20-UNDERTAKER Mrs E. Hanson

ADDRESS 478 S. Ch

D.46978 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46978

CERTIFICATE OF DEATH.

104-091

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1105 Druid Hill Ave ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leroy Anderson

(Residence in Baltimore: No. 1105 Druid Hill Ave, St.; yrs., 4 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, May 17, 1920 (Month) (Day) (Year)

7-AGE, yrs. 4 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none (Dependent)
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Ivory Anderson

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Bessie Jones

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Jones

(Address) 1105 Druid Hill Ave

15- Filed OCT 2 - 1920, 191 Robert P. Harrison, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 30, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Gastro-enteritis

(Duration) yrs. mos. 2 ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Oct. 1, 1920 (Address) 2302 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Oct. 2 1920

20-UNDERTAKER Paul E. Wendler ADDRESS 378 N. Bond St.

N.B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46979 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46979

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1526 E. Fayette St.: 6. WARD) REGISTERED NO. 79

2-FULL NAME Theodore Wright.

(a) RESIDENCE. No. 1526 E. Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 30 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	8			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Wright

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Lillian Cuttle

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant John Wright.
(Address) 1526 E. Fayette St.

15 Filed OCT 2 1920. 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9. 1920. to Sept. 30. 1920. that I last saw him alive on Sept. 30 1920. and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert F Green M. D.

Oct. 1. 1920 (Address) 120½ Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Asbury Cem.	Oct 3 '20

20 UNDERTAKER Chas. W. Johnson ADDRESS 461 N. Carlton

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46980 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46980

CERTIFICATE OF DEATH. 54.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Haase

(a) RESIDENCE. No. Cor. Wolfe & Alice Ann STS WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigarmaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER William Haase

11 BIRTHPLACE OF FATHER (city or town) Europe
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Europe
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed ..... 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1920 to Sept. 30, 1920 that I last saw h... alive on September 29, 1920 and that death occurred, on the date stated above, at 5:15 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious anemia.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood examination.

(Signed) Bitterman M. D.

9/30/19 20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	Oct. 2 19
20 UNDERTAKER Lilly & Zeile	ADDRESS 403 Mon... St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

OCT 2-1920
Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

~~142933~~ 20.46981

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.46981

CERTIFICATE OF DEATH.

3/2

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard C Lappell.

(a) RESIDENCE. NO. 336 W. Biddle St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	12	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George C Lappell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida May Bell.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) J. Hall Baltimore.

15 Filed OCT 2 - 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1920, to Aug 30, 1920, that I last saw h[illegible] alive on Aug 30, 1920, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonelis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) V R Macon, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery,	193/ 20.
20 UNDERTAKER	ADDRESS
George J. Ruth	1735-Hayward Av

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D-46982 HEALTH DEPARTMENT—CITY OF BALTIMORE D-46982

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 N Gilmor ST.; 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah L Burns

(Residence in Baltimore: No. 923 N Gilmor St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 18 (Month) (Day), 1857 (Year)

7-AGE, 63 yrs. 5 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Martin Carey

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Smith

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward J Burns

(Address) 923 N Gilmor St

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 1, 1920, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 30 1920, to Sept. 30 1920, that I saw her alive on Sept. 30 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

10/2, 191.. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, Oct. 4, 1920

20-UNDERTAKER Martin Fahey & Sons — ADDRESS 827 N North Ave

(over)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact... important. See instructions on back of certificate.

Spec.—6-8-19—H. P. Co.—1000 Bks.

D.46983 HEALTH DEPARTMENT—CITY OF BALTIMORE D-46983

CERTIFICATE OF DEATH. 104V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3442 Hickory ave ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norma Karl Williams

(a) RESIDENCE. No. 3442 Hickory ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24 1919

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD

PARENTS

10 NAME OF FATHER Ralph Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) MD

12 MAIDEN NAME OF MOTHER Lillian George

13 BIRTHPLACE OF MOTHER (city or town) (State or country) MD

14 Informant Ralph Williams

(Address)

15 Filed OCT 2 - 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 28 1920, to Oct 1st 1920, that I last saw her alive on Oct 1/20 and that death occurred, on the date stated above, at 7 20 P m.

The CAUSE OF DEATH* was as follows:

Enteritis Endocarditis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Eclampsia

(duration) yrs. mos. 1/3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of —

Was there an autopsy? NO.

What test confirmed diagnosis? General Conclusion Phy. Sign

(Signed) R. B. Normeut, M. D.

10/2/1920 (Address) 3643 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Oct 2 1920

20 UNDERTAKER Greenwell & Son ADDRESS Chestnut Ave

mation should be carefully supplied. Name of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.46984 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46984

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 3720 Falls Rd., ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Levi H. Sterner

(Residence in Baltimore: No. 3720 Falls Rd. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widowed

6-DATE OF BIRTH. Nov. 7th, (Month) 1848 (Day), 1 (Year)

7-AGE			If LESS than 1 day,
70 yrs.	10 mos.	23 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), York Co., Pa.

PARENTS.

10-NAME OF FATHER, Henry Sterner

11-BIRTHPLACE OF FATHER (State or Country), Penna.

12-MAIDEN NAME OF MOTHER Mary Herbst

13-BIRTHPLACE OF MOTHER (State or Country), Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. J. Sterner

(Address) 3405 Chestnut Ave., City.

15-

Filed, 191

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sep't 30th, (Month) 1920 (Day) 191 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1st, 1920, to Sep't 30. 20 191, that I saw him alive on Sep't 29, 1920 191, and that death occurred, on the date stated above, at 10:20 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstial Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Prostatis

(Duration) 1 yrs. mos. ds.

(Signed) J. B. Culbertson M. D.

9/30, 1920 (Address) 1800 Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence New Freedom Pa

19-PLACE OF BURIAL OR REMOVAL. Lutz Church New Freedom DATE OF BURIAL. Oct 3, 1920.

20-UNDERTAKER D. S. Marshall ADDRESS 3637 Falls Rd.

N. B.—Every item of information must be given in plain terms, so that it may be properly classified. Exact CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

D.46985 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46985

CERTIFICATE OF DEATH.

79 V

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. Maryland General Hosp ST.: 8 WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Johanna Rose

(Residence in Baltimore: No. 1505 N. Gay St.; 43 yrs., 9 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, Dec. 24, 1876 (Month) (Day) (Year)

7-AGE, 43 yrs. 9 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Duties
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: John Philip Reisinger

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Mary Dridde

13-BIRTHPLACE OF MOTHER (State or Country): Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Otto Rose

(Address) 1505 N. Gay St.

15- Filed OCT 2 1920, 191.... Robert P. Harrison, Registrar. Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated in years and months. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 1, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said (Inquest, autopsy or inquiry.) jury find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Organic heart disease

(Duration) yrs. mos. ds.

(Signed) J. C. Hemmeter M. D. (Coroner.)

October 1, 1920. (Address) 2802 Edgewood Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1505 N. Gay St.

Former or usual residence Same.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Immanuels Cem	Oct. 4., 19.20
20-UNDERTAKER	ADDRESS
Sons Herman	325 E Broadway

D 46986

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 D 46986

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 1372 Calhoun St. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Yeaber.

(Residence in Baltimore: No. 1372 Calhoun St.: 3 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
male	colored	single.

6 DATE OF BIRTH November, 1884
(Month) (Day) (Year)

7 AGE 36 yrs. — mos. — ds. | If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Waiter 186
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Richmond Co Va

PARENTS

10 NAME OF FATHER John Yearley

11 BIRTHPLACE OF FATHER (State or country) Richmond Co Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) Richmond Co Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
JAMES H. DENNIS
(Informant)
1303 PRESTMAN ST.
(Address)

15 Filed OCT 2 - 1920, 191 Robert P. Harrison, REGISTRAR
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 30, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20. 1920, to. Sept 30 1920, that I saw h~~e~~r alive on Sept 29 1920, and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 2 mos. ds

Contributory (SECONDARY) Cardiac Dilatation

(Duration) yrs. 1 mos. ds.

(Signed) Hubert C Blake M. D.
Sept 30, 1920. (Address) 1014 N Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.

Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Sharp Street Richmond Co Va | DATE OF BURIAL Oct 13 1920

20 UNDERTAKER JAMES H. DENNIS ADDRESS 1303 PRESTMAN ST.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Examination of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46987

D46987

104

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 N. Robinson St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Eoole.

(a) RESIDENCE. NO. 317 N. Robinson ST., 6 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 15th 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
		11	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Harry Eoole.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Nora A. Hickman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co. Md

14 Informant Harry Eoole (Father)
(Address) 317 N. Robinson St.

15 Filed Oct 2 1920 19 Robert F. Harris
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1st 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 23 1920 to Oct 1 1920
that I last saw h— alive on Sept 30 1920
and that death occurred, on the date stated above, at 2 a. m.
The CAUSE OF DEATH* was as follows:

Acute Enteritis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Massy- Md.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John L. Owens, M. D.
Oct 1. 1920 Address Farmers Bk + Potomac

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Oct. 2nd 1920
20 UNDERTAKER	ADDRESS
Lilly + Zeiler	403 N Wolfe

be properly classified. Exact statement of OCCUPA
of certificates.
mation should be carefully supplied. Age should be
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Bks.

D46988

HEALTH DEPARTMENT—CITY OF BALTIMORE

D46988

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph's Hospital

REGISTERED NO. 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Oliver & Caroline ST.: 2 WARD)

2-FULL NAME Elizabeth Brown

(a) RESIDENCE. NO. 237 S Wolf ST., 2 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elmer Brown.

6 DATE OF BIRTH (month, day, and year) May 9th 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm Lovell.

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Annie Beler.

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Annie Beler (Mother)
(Address) 719 S Durham St.

15 Filed ....., 19 Robert P. Harrison Registrar

OCT 2 - 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1920, to Sept. 30, 1920, that I last saw h er alive on Sept. 30, 1920, and that death occurred, on the date stated above, at 6 20 P. m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) W. T. Riley, M. D.

, 19 (Address) 1639 N. Broadway St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Oct. 4th 1920
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. [illegible]

N. B.—[illegible] should be carefully supplied. AGE [illegible] mation should be properly classified. Exact CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46989 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46989

CERTIFICATE OF DEATH. 43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1049 W Fayette (St.) 18 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A Coomes

(a) RESIDENCE. No. 1049 W Fayette St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. Coomes

6 DATE OF BIRTH (month, day, and year): 1856

7 AGE: Years 64; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Don't Know

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't Know

14 Informant (Address): Mrs Coomes 1049 W Fayette St

15 Filed 19 Registrar

OCT 2 - 1920

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-1 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1920, to Oct 1, 1920, that I last saw h alive on Sept 30, 1920, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Cancer of Breast (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulm Oedema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T. Flemming Norwood, M. D.

, 19 (Address) 1539 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D C — DATE OF BURIAL: Oct 4 1920

20 UNDERTAKER: W. E. Cook — ADDRESS: 102 E Hoffman

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE ... should be stated EXACTLY. The ... mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

20.46990

HEALTH DEPARTMENT--CITY OF BALTIMORE

20.46990

CERTIFICATE OF DEATH

642

REGISTERED No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3302 Clifton Ave. 15 STR. WARD)

2 FULL NAME William Nicholas Mathews

(Residence in Baltimore: No. 3302 Clifton ave. St.: 71 yrs. mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
M.	W.	widower

6 DATE OF BIRTH Sept. 15, 1849 (Month) (Day) (Year)

7 AGE 71 yrs. mos. 16 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Clerk, 809
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Nicholas Mathews

11 BIRTHPLACE OF FATHER (State or country) Balto md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edgar K. Mathews

(Address) 4305 Maine Ave

15. Robert P. Harrison,

Filed OCT 2 - 1920, 191 Burial Permit Clerk.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 1, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1920, to Oct 1 1920, that I saw him alive on Oct 1, 1920, and that death occurred, on the date stated above, at 9.45 a m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis - myocarditis.

(Duration) 9 yrs. mos. ds

Contributory (SECONDARY) Cerebral Hemorrhage

(Duration) yrs. mos. 3 ds.

(Signed) H. S. Hibbett M. D.

Sept Oct 1, 1920 (Address) 3402 Clifton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
London Park	Oct 4, 1920
20 UNDERTAKER George J. Smith	ADDRESS [illegible]

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PEARL, WHITE SWAN

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.46991 D.46991

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 Harwood Ave ST.; 17 WARD)

2-FULL NAME Sarah Gallagher

(a) RESIDENCE. NO. 324 Harwood Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs — mos. — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Neill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Jas L. Finnegan 324 Harwood ave

15 Filed ..., 19.. Robert P. Harrison, Registrar

OCT 24 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1920, to Oct 21, 1920, that I last saw h... alive on Oct 21, 1920, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) Wm H Paul, M. D.

Oct 22 1920 (Address) 205 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	10/24 1920

20 UNDERTAKER Chas F. Evans Son ADDRESS 118 W. Mt. Royal ave

N. B.—WHITE PLAINLY. All questions must be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.46992 HEALTH DEPARTMENT—CITY OF BALTIMORE D.46992

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH St. Joseph's Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Caroline & Oliver ST.: 20 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm H. Burton

(a) RESIDENCE. NO. 2514 W. Baltimore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	M

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Mary A Burton

6 DATE OF BIRTH (month, day, and year) 9 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) 078

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Jas. E. Burton

11 BIRTHPLACE OF FATHER (city or town) Lutherville (State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Robt Burton (Address) Baltimore Md

15 Filed ..... 19 ..... Registrar

OCT 2 - 1920 Robert P. Harrison

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1919, to Oct. 2, 1920 that I last saw h~~im~~ alive on Oct. 2, 1920 and that death occurred, on the date stated above, at 3 50 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Hypertrophic Arthritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm T Riley, M. D.

, 19 (Address) 1639 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Oct 4 1920
20 UNDERTAKER Robert Brookerson	ADDRESS W. B. Caltimore

N. B.—WRITE PLAINLY. ALL the questions should be answered. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.46993

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.46993

CERTIFICATE OF DEATH.

152

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Primrose Ave. & Main ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Un-named Infant

(Residence in Baltimore: No. Primrose Ave & Main St.; ....yrs., ...mos. ....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct (Month) 2 (Day), 1920 (Year)

7-AGE, 15 minutes ....yrs. ....mos. ....da.

If LESS than 1 day, ...hrs. or 15 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Walter Marshall

11-BIRTHPLACE OF FATHER (State or Country), Balto Co Md.

12-MAIDEN NAME OF MOTHER Harriet Snyder

13-BIRTHPLACE OF MOTHER (State or Country), U S

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs R. Marshall

(Address) Main St Arlington

15-

Filed OCT 2 - 1920, 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 2nd (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1920, to Oct 2 1920, that I saw him alive on Oct 2 1920, and that death occurred, on the date stated above, at 1.05 a.m.

The CAUSE OF DEATH* was as follows:

Atelectasis Pulmonum

15 minutes (Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) Premature Birth

.... (Duration) ....yrs. ....mos. ....da.

(Signed) Ed. B. Gosson M. D.

Oct 2, 1920 (Address) Park Ave & Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Harrison Vic Protestant Church

DATE OF BURIAL, Oct 4, 1920

20-UNDERTAKER F. A. Jones

ADDRESS 14 N Green

N.B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. It may be important. See instructions on back of certificate.

OCT 2 - 1920

Burial Permit Clerk.

D 46994 Harry C. Preston D 46994

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 PLACE OF DEATH — CITY OF BALTIMORE (No. 933 Hillen St.; Ward) 5 — Registered No. C 168

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Harry C. Preston

(Residence in Baltimore: No. 933 Hillen St St.; yrs.,, mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, Sept. (Month) 9 (Day), 1886 (Year)

7-AGE, 34 yrs. — mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Medical 054
(b) General nature of industry, business, or establishment in which employed (or employer): Hospital

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Preston

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. L. H. Baugman
(Address) Manchester Md.

15- Filed OCT 3 - 1920, 191.... ROBERT B KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) / 1 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Inhalation of Chloroform.
accidental Duration
(Duration) ....yrs. ....mos. 17 ds.
CONTRIBUTORY (Secondary) Cardiac Dilatation
(Duration) ....yrs. ....mos. 1 ds.

(Signed) Fred A. White M. D.
(Coroner.)
10/2 Fw, 191.. (Address) 1414 Eutaw Bmore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Manchester Md — DATE OF BURIAL: Oct 2, 1920

20-UNDERTAKER: W M Routson — ADDRESS: 230 N Grand

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D46995 HEALTH DEPARTMENT—CITY OF BALTIMORE D46995

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1739 E Fairmount ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aaron Zeke Chidecksel

(Residence in Baltimore: No. 1739 E Fairmount St.; 30 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, ..., 1830
(Month) (Day) (Year)

7-AGE, 90 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Gerson Chidicksel

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1411 E Balto St

15-
Filed OCT 3 - 1920, 191.....
ROBERT E KRAUTER
Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 3rd, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 22 1920, to Oct 3 1920, that I saw him alive on Oct 2nd 1920, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Bronchs-pneumonia

..... (Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion

..... (Duration) yrs. mos. 1 ds.

(Signed) I W Keown M. D.

Oct 3, 1920 (Address) 1938 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale — DATE OF BURIAL, Oct 3, 1920

20-UNDERTAKER Jack Lewis. — ADDRESS 1411 E. Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L46996 L46996 X 138 L46996

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Riverview Ave W/s 5th Ave St.: 26 (Ward)

2-FULL NAME Marian Myrtle Eastman

(a) RESIDENCE. No. Riverview Ave E/s 5th Ave St., 26 Ward. Montreal Canada

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. 9 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Eastman

6 DATE OF BIRTH (month, day, and year) Oct 29 - 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Quebec Canada

PARENTS

10 NAME OF FATHER John McMahon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montreal Canada.

12 MAIDEN NAME OF MOTHER Mary Ann Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Quebec Canada.

14 Informant John J. Eastman (Address) Riverview Ave W/s 5th Ave

15 Filed OCT 3 - 1920 ROBERT P. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1920, to Oct 2, 1920, that I last saw her alive on Oct 2, 1920, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Eclampsia, Puerperal.

(duration) yrs. mos. 10 hrs

CONTRIBUTORY (Secondary) Convulsions Heart failure Anemia

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? Ob plan of death Delivery, 10/2/20

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptom.

(Signed) J. M. Carmine, M. D.

, 19 (Address) St. Helena, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cote de Neiges Cem. Montreal, Can. Canada. DATE OF BURIAL Oct. 6 1920

20 UNDERTAKER Lilly and Zeiler. ADDRESS 403 S. Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be stated EXACTLY. PHYSICIANS should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

~~D~~ 46997 HEALTH DEPARTMENT—CITY OF BALTIMORE D 46997

CERTIFICATE OF DEATH.

169

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Foot of McComas St. ST.: 8 WARD)

REGISTERED No. C....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilbur Beck.

(Residence in Baltimore: No. 2101 E. Oliver St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, December 31st. 1896, 1 (Month) (Day) (Year)

7-AGE, 23 yrs. 9 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Pipe lineman.
(b) General nature of industry, business, or establishment in which employed (or employer): 686

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, William Beck.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Mary Buchta.

13-BIRTHPLACE OF MOTHER (State or Country), St Marys Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Beck. (father)

(Address) 2101 E. Oliver St.

15- OCT 3 - 1920 ROBERT E KRAUTER
Filed....., 191.... (Burial) Permit (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 1st. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Accidental fall overboard while working on dredge Potomac.
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M Rossbach M. D. (Coroner.)

Oct. 2, 1920 (Address) 1617 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem	10/4/20, 19....
20-UNDERTAKER Henry Lutz	ADDRESS 1007 Bond St

1046998 HEALTH DEPARTMENT—CITY OF BALTIMORE V1046998

CERTIFICATE OF DEATH. X 186

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) John Hopkins Hosp ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Mollie Kaplan

(Residence in Baltimore: No. 34 S. Bond St X St.; yrs., 3 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, white | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 5 (Day), 1914 (Year)

7-AGE, 6 yrs. 2 mos. 27 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Clearfield Pa

PARENTS.

10-NAME OF FATHER, Samuel Kaplan

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Lillie Chosid

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Levis

(Address) 1411 E Balto St

15-

Filed OCT 3 - 1920, 191.... ROBERT R. KRAUTER Registrar. BURIAL PERMIT

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 2 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the dny stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures
of Bones

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. C. Blair M. D.

(Coroner.)

10/4 191... (Address) 1413 E. Bon...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Clearfield Pa

19-PLACE OF BURIAL OR REMOVAL, Rehrem Washington Pk | DATE OF BURIAL, 10-3 19 20

20-UNDERTAKER Jacob Levis | ADDRESS 1411 E Balto St

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1046999 40 1046999

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. New City Hospital. ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Parawcz

(a) RESIDENCE. NO. 850 S. Bond St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austrian

PARENTS

10 NAME OF FATHER Lukas Poles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tarenol, Poland

12 MAIDEN NAME OF MOTHER Marie Posluck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tarenol, Poland.

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed OCT 3 — 1920 ROBERT F. FLACTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 1, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1920, to October 1, 1920.

that I last saw h im alive on October 1, 1920.

and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of pharynx.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Tissue section

(Signed) V. Herman, M. D.

10/1/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 4 1920

20 UNDERTAKER John F. Weber ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY. Words should be spelled out. AGE should be stated EXACTLY. If less than one day, the exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1047000 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047000

CERTIFICATE OF DEATH. 1820

1-PLACE OF DEATH W

CITY OF BALTIMORE (No. 1315 Saratoga ST.: 19 WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie Tucker

(Residence in Baltimore: No. 1315 W Saratoga St.: 1 yrs., 5 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, Jan 1, 1891 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
29 yrs. 9 mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Ed. J. Bradshaw

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER M. E. Bradshaw

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Eunice Hemyatt

(Address) 1315 W. Saratoga St

15-

OCT 3 - 1920 ROBERT B. KRAUTER

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 2, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

3 Gun Shot wounds - Chest Homicide

(Duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Timbers M. D. (Coroner.)

Oct 2, 1920 (Address) 710 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Suffolk Va,	Oct 3, 1920
20-UNDERTAKER George L. Smith	ADDRESS Suffolk Va

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047001

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047001

CERTIFICATE OF DEATH.

120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 N. Lexington St.; 18 WARD)

2-FULL NAME Margaret Laughlin

(a) RESIDENCE. No. 824 N. Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harry Laughlin

6 DATE OF BIRTH (month, day, and year) Jan. 18-1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER John Tuttle

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget McCarty

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Harry Laughlin
(Address) 824 W. Lexington

15 Filed OCT 3 - 1920 ROBERT P. LEA Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30th 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1920, to Sept. 30th, 1920, that I last saw h. alive on Sept. 30th, 1920, and that death occurred, on the date stated above, at 3:45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Eclampsia 3 Days.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. J. Murray, M. D.

(Address) 510 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peter's Cemetery	9/4/20

20 UNDERTAKER H. L. Branning

ADDRESS 517 N. Schroeder

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

947002

HEALTH DEPARTMENT—CITY OF BALTIMORE

40 947002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1127 Madison Ave ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Thompson

(a) RESIDENCE. NO. 1127 Madison Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Thompson

6 DATE OF BIRTH (month, day, and year) Dec 13 - 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	49	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) London - Engl.

PARENTS

10 NAME OF FATHER Wm. H Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Henrietta Feinburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Charles Thompson
(Address) 1127 Madison Ave

15 Filed OCT 3 - 1920 HOWARD A. KRAUTZ Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1920

17

I HEREBY CERTIFY, That I attended deceased from June, 1920, to Oct 2, 1920,

that I last saw her alive on Oct 1, 1920,

and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis etc of arteriosclerosis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? Yes Date of Sept 1-20

Was there an autopsy? No

What test confirmed diagnosis? Exploratory Laparotomy

(Signed) J Frederick Leitz, M. D.

Oct 2 1920 (Address) 2040 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state: (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 4 1920
20 UNDERTAKER William Cook	ADDRESS 5032 E. Nat'l Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr. Leitz - 2040 Eutaw Place

Spec.—6-1-19—H. P. Co.—1000 Bks.

Washington 682 Columbia Ave

1047003

HEALTH DEPARTMENT—CITY OF BALTIMORE.

1047003

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 869 Lumbard ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Oscar Jessop

(a) RESIDENCE. NO. 869 Lumbard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 6 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 609

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co Md

PARENTS

10 NAME OF FATHER Dominick Jessop

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Arietta Lowe (Address) 869 Lumbard St

15 Filed ..., 19... Registrar

OCT 3 1920 ROBERT P. FRASIER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to Oct 1, 1920, that I last saw her alive on Oct 1, 1920 and that death occurred, on the date stated above, at 10 30a m.

The CAUSE OF DEATH* was as follows:

Pulmonary and Laryngeal Tuberculosis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Friedinger M.D. M. D.

(Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 4 1920
20 UNDERTAKER	ADDRESS
Wm Cook	1424 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

682 Columbia ave

1047004 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 1047004

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 610 Island st ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Marbury

(Residence in Baltimore: No. 610 Island — St.: 3 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Aug 4, 1878 (Month) (Day) (Year)

7-AGE, 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), N. C.

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER Virginia Vance

13-BIRTHPLACE OF MOTHER (State or Country), S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Vance

(Address) 610 Island St

15- OCT 3 - 1920 ROBERT B. BRAUTER

Filed ....., 191 BURIAL PERMIT ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 2, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary disease of the Heart — Don't Know (Duration) yrs. Don't Know mos. ds.

CONTRIBUTORY (Secondary) Don't Know — Don't Know (Duration) yrs. mos. ds.

(Signed) W. H. Formwalt (Coroner.) M. D.

(Address) 90 S. 1920 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs..mos..ds. In the State ..yrs..mos..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Spotsylvania C. — DATE OF BURIAL, Oct 3, 1920

20-UNDERTAKER Clement Hall — ADDRESS 1945 Fenwick

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047005 1047005 1047005

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Mitchell

(a) RESIDENCE. NO. Turners Station ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred First yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Mitchell

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Eliza Bedford

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant Hospital Record
(Address) J. H. H.

15 Filed OCT 3 - 1920 ROBERT F. KLAUTER Registrar
Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1st 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1920, to Oct 1st, 1920, that I last saw h[illegible] alive on Oct 1st, 1920, and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Brain Abscess

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Puncture wound of head

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

(Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Oct 4 1920.

20 UNDERTAKER Felix B. Pyle ADDRESS 1036 Mulberry St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

1947006

HEALTH DEPARTMENT—CITY OF BALTIMORE

1947006

CERTIFICATE OF DEATH.

80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1612 Riggs ave (St.) 16 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Burman

(a) RESIDENCE. No. 1612 Riggs ave St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa- TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan - 1888

7 AGE: Years 32 Months 9 Days —

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abraham Konginsky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jacob Burman

(Address) 1612 Riggs ave

15 Filed OCT 3 - 1920 19.....

ROBERT B. LEAUTEE

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1920, to Oct 3, 1920,

that I last saw h.. alive on Oct 2, 1920

and that death occurred, on the date stated above, at 4 a 1 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Pulmonalis.

(duration) 1919 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thomas Nelson, M. D.

19 (Address) 1001 N Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington Rd

DATE OF BURIAL: Oct 3, 1920

20 UNDERTAKER: Max Levinson

ADDRESS 1127 E Baltimore st

47007 HEALTH DEPARTMENT--CITY OF BALTIMORE D. 47007

CERTIFICATE OF DEATH

REGISTERED No. C 64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3511 Springdale Ave St.: 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Drucilla Faught

(Residence in Baltimore: No. 3511 Springdale Ave St.: 17 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widowed

6-DATE OF BIRTH Feb (Month) 24 (Day), 1842 (Year)

7-AGE 78 yrs. 7 mos. 9 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): (0)

9-BIRTHPLACE (State or country) Maine

PARENTS

10-NAME OF FATHER Seth Robinson

11-BIRTHPLACE OF FATHER (State or country) New Hampshire

12-MAIDEN NAME OF MOTHER Harriet Frost

13-BIRTHPLACE OF MOTHER (State or country) Maine

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. C. Faught

(Address) 3511 Springdale Ave

15. Filed OCT 4 - 1920, 19.. ROBERT B KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Oct (Month) 3rd (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 15, 1920, to Oct 2 1920, that I saw h.. alive on Oct 2 1920 and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

Arteria - Sclerosis

(Duration) 10 yrs. — mos. — ds

Contributory (SECONDARY) Cerebral Congestion

— (Duration) — yrs. — mos. 30 ds.

(Signed) John J. Young M. D.

Oct 23, 1920 (Address) 1425 - Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Sidney - Maine

DATE OF BURIAL: Oct. 4, 1920

20-UNDERTAKER: H. Allen Fuller

ADDRESS: 3517 Springdale

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D47008

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47008

CERTIFICATE OF DEATH.

120

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 Jefferson ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. Wilson

(Residence in Baltimore: No. 807 Jefferson St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, March 9, 1858 (Month) (Day) (Year)

7-AGE 62 yrs. 6 mos. — ds.

If LESS than 1 day, —hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, ?Unknown

11-BIRTHPLACE OF FATHER (State or Country), ?Unknown

12-MAIDEN NAME OF MOTHER ?Unknown

13-BIRTHPLACE OF MOTHER (State or Country), ?Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm H. Wilson

(Address) 807 Jefferson St

15- ROBERT B KRAUTER

Filed OCT 4 - 1920, 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 30, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 28 Aug. 1920, to 30 Sept. 1920, that I saw her alive on 29 " 1920, and that death occurred, on the date stated above, at 2.20 p.m.

The CAUSE OF DEATH* was as follows: Interstitial nephritis, Myocarditis.

Probably sometime. (Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Broken Cardiac failure Senile (Duration) yrs. mos. ds.

(Signed) Edwin Field Boyce M. D.

30/9/1920 (Address) 475 N. Carlton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Oct 4, 1920

20-UNDERTAKER Mrs J. S. Locks ADDRESS 1302 Jeffer...

N. B.—Every item of information should be carefully supplied. A CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY.

Spec.—8-24-14—M. & T.—2000 Bks.

D 47009 HEALTH DEPARTMENT—CITY OF BALTIMORE D47009

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2301 N. Charles ST. 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pamela Seager

(Residence in Baltimore: No. 2301 N. Charles St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	single

6-DATE OF BIRTH, Oct (Month) 3 (Day), 1836 (Year)

7-AGE 86 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Thomas Seager

11-BIRTHPLACE OF FATHER (State or Country), N.Y.

12-MAIDEN NAME OF MOTHER Mary

13-BIRTHPLACE OF MOTHER (State or Country), N.Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm McCormuck

(Address) Homewood Sports

15-

Filed ....., 191.....

Registrar.

OCT 4 - 1920

ROBERT P. LAZZATI

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 3 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 20 1920, to Oct. 3 1920, that I saw her alive on Oct. 2 1920, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Senility (Coma)

Passive Cerebral Hyperemia ?

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. ds.

(Signed) A. E. Bobe M. D.

Oct. 3, 1920. (Address) 20 E. Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Mount

DATE OF BURIAL, Oct. 4, 1920

20-UNDERTAKER J. O. Mitchell

ADDRESS 1201 N. Fayette St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D47010

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47010

CERTIFICATE OF DEATH.

79

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 Penna ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catharine Gleitsman

(Residence in Baltimore: No. 918 Penna ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Femal

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 8, 1857 (Month) (Day) (Year)

7-AGE, 61 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Baltimore md.

PARENTS.

10-NAME OF FATHER, William Markolf

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (State or Country) Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Otto Gleitsmann

(Address).....

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 30th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 26th 1920, to Sept 30th 1920, that I saw h[er] alive on Sept 30th 1920, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

Mitral incompetence

(Duration) 2 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Not known

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas J Keelan M. D.

Oct 2, 191.. (Address) 1 E Lexington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. London Parkbur

DATE OF BURIAL, Oct 4, 1920

20-UNDERTAKER Daniel Easton

ADDRESS 916 Ea ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should also CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47011 HEALTH DEPARTMENT—CITY OF BALTIMORE D47011

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 East West ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Neumann

(a) RESIDENCE. No. 123 East West ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frank Neumann

6 DATE OF BIRTH (month, day, and year) May 20, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 037

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Neumann (Address) [illegible]

15 Filed OCT 4 - 1920 ROBERT S. BRAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1920

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 1916, to Oct 1st, 1920, that I last saw h[illegible] alive on Oct 1st, 1920, and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(duration) 4 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. W. Simpson, M. D.

Oct 1, 1920 (Address) 301 East Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross C & C Co.	10-4 1920
20 UNDERTAKER Edward B Hanlon	ADDRESS 115 E Preston

D47012 HEALTH DEPARTMENT—CITY OF BALTIMORE D47012

CERTIFICATE OF DEATH.

103

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 212 S. Bethel ST.: 3 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aulid Perry

(Residence in Baltimore: No. 212 S. Bethel. St.; 27 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F. 4-COLOR OR RACE, C- 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, ..., 1867
(Month) (Day) (Year)

7-AGE, 53 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Work
(b) General nature of industry, business, or establishment in which employed (or employer): 970

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Jolley

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Annie Jolley

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blandine Perry

(Address) 212 S. Bethel st

15-OCT 4 - 1920 Filed ....., 19.... ROBERT B KRAUTER Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 10 / 1 / 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

No Particulars

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Wm Martin Brady, M. D.
(Coroner.)

10/1/20, 19... (Address) 145 N. Howard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Asbury — DATE OF BURIAL, Oct 4, 1920

20-UNDERTAKER John W Henderson — ADDRESS 1502 E Monument

WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.

1047013 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047013.

CERTIFICATE OF DEATH.

159

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Sq Hospital St. 27 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kenneth Tucker

(Residence in Baltimore: No. 118 Cedar Ave (Evergreen) St. (yrs., 37 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec 10, 1900
(Month) (Day) (Year)

7-AGE, 19 yrs. 9 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... RR Brakeman
(b) General nature of industry, business, or establishment in which employed (or employer)..... B&O R.R.

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Eugene S Tucker

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Susie Jones

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eugene S Tucker

(Address) 1103 Lanvale St

15- OCT 4 - 1920 ROBERT P. KRAUTER

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 2, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Two Bullet Wounds in head one Entering the Brain Suicide

(Duration) ..... yrs. ..... mos. Sudden ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Fowler M. D.
(Coroner.)

Oct 2, 1920 (Address) 1002 Clare St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

1315 W Saratoga St

Former or usual residence 118 Cedar Ave

19-PLACE OF BURIAL OR REMOVAL, Cem Church Forest Hill Harford Co Md

DATE OF BURIAL, Oct 4th, 1920

20-UNDERTAKER Liston P. Fussellbaugh

ADDRESS 2620 St Paul St,

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47014

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47014

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital, St.: 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A Batch

(a) RESIDENCE. No. Raspeburg Md. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 10 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 27 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45 yrs	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Raspburg Md

PARENTS

10 NAME OF FATHER Thomas B Batch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Raspburg Md

12 MAIDEN NAME OF MOTHER Josephine Forestis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Raspburg Md

14 Informant Thomas B Batch
(Address) Raspburg Md

15 Filed OCT 4 — 1920 19 ROBERT J. KLUTTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/3 1920

17 I HEREBY CERTIFY, That I attended deceased from September 29 1920, to October 3, 1920, that I last saw him alive on October 3, 1920, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Typhoid Perforation

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Oct 2-1920

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. G. Speer, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Batch's Family Cemetery Raspburg Md	Oct 5th 1920
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

G INK—THIS IS A PERMANENT RECORD. PHYSICIANS should write
AGE should be stated EXACTLY. AGE
o that it may be properly classified. Exact statement of OCCUPA-
tions on back of certificates.
CAUSE OF DEATH in plain terms, so that
TION is very important. See instructions

Siebert

1047018 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047018

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3318 Auchentroly St. 13 WARD) REGISTERED NO. C. 19

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Siebert

(Residence in Baltimore: No. 3318 Auchentroly Ter St. yrs., mos. da.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, ~~Female~~ Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June 1st 1870, 1 (Month) (Day) (Year)

7-AGE, 50 yrs. 4 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Geo Rousch

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dora Wolfe

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Siebert

(Address) 3318 Auchentroly

15-

Filed OCT 4 - 1920, 191.... ROBERT B. KRAUTER Registrar.

Burial ... Oct 6th

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 2 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry) ...and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) John Harriman M. D. (Coroner.)

Oct 3 1920 (Address) 3692 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge | DATE OF BURIAL, Oct 4, 1920

20-UNDERTAKER W J Lichtner Sons | ADDRESS North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

1947016

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

1947016

1 PLACE OF DEATH

REGISTERED NO. C 78

CITY OF BALTIMORE: (No. 2844 Hanford Road St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Elizabeth Broome

(Residence in Baltimore: No. 2844 Hanford Rd St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: February (Month) 7 (Day), 1856 (Year)

7-AGE: 64 yrs. 7 mos. 23 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer): 069

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Chas C Sequeltz

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Sarah E Robinson

13-BIRTHPLACE OF MOTHER (State or country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Virginia L Sequeltz

(Address) 2844 Hanford Rd

15- Filed OCT 4 - 1920, 191 ROBERT B BRAUTER Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: October (Month) 1 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 16, 1920, to, October 1 1920, that I saw h.. alive on Oct 1 1920, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis. (Duration) yrs. mos. 5 ds.

Contributory (SECONDARY) Acute dilatation (Duration) yrs. mos. 4 wks.

(Signed) Thos Fa Stevens M. D.

Oct. 1, 1920 [Address] 2866 Hanford Rd

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: October 4, 1920

20-UNDERTAKER: H Sander & Son

ADDRESS: 1710 Fleet St

Spec.—6-9-19—H. P. Co.—1000 Bks.

1947017

HEALTH DEPARTMENT—CITY OF BALTIMORE

1947017

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1624 E. Oliver ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Dietz

(a) RESIDENCE. No. 1624 E. Oliver ST., 8 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah R. Dietz

6 DATE OF BIRTH (month, day, and year): Feb 13 - 1831

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	89	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ship Wright & C

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 2 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Dietz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Marie Kalbfleish

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Sarah R. Dietz
(Address): 1624 E. Oliver St

15 Filed OCT 4 - 1920 ROBERT F. LEADER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 2nd 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1920, to Oct 2, 1920, that I last saw h. m. alive on Oct 2, 1920, and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. D. Meadows M. D.

Oct 3 1920 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 5 1920
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet

Spec.—6-9-19—H. P. Co.—1000 Bks.

2047018

HEALTH DEPARTMENT—CITY OF BALTIMORE

2047018

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Davis.

(a) RESIDENCE. No. 1551 S. Clinton St. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Wales

PARENTS

10 NAME OF FATHER: William Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records,
(Address): New City Hospital.

15 Filed OCT 4 - 1920 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 1, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1920 to October 1, 1920.

that I last saw h. im alive on September 30, 1920.

and that death occurred, on the date stated above, at 5:15 A. m.

The CAUSE OF DEATH* was as follows:

Acute myocardial insufficiency

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Congenital polycystic kidneys (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) [illegible] M. D.

10/1/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel.	Oct 4th 1920
20 UNDERTAKER	ADDRESS
Geo. G. Cook	North & Hadfield Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1047019

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: 5 Ward)

REGISTERED NO. 1047019

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorain Richardson

(a) RESIDENCE. No. 1203 Jefferson St. Baltimore Md. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	~~White~~ Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 21 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Leon Richardson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Inez Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant J.H.H.
(Address)

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1920, to Oct 2nd, 1920, that I last saw h[illegible] alive on Oct 2nd, 1920, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) — yrs. — mos. 12 da.

CONTRIBUTORY (Secondary) Syphilis

(duration) — yrs. — mos. 12 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. C. Dawson, M. D.

, 19 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Caus[es] state (1) Means and Nature of Injury, and (2) whether Accide[ntal] Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemetery

DATE OF BU[RIAL] Oct [illegible]

20 UNDERTAKER R. C. Gross 1405 McC[ulloh]

ADDRESS

1047020 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047020

CERTIFICATE OF DEATH.

REGISTERED No. C 175-001

PLACE OF DEATH

CITY OF BALTIMORE (No. 709 Sarah ann ST.: 4 WARD) (If death occurred in hospital or institution give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME John W. Christian

(Residence in Baltimore: No. 709 Sarah ann St) 32 yrs., mos. da.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... Dont Know ....., 1 .....
(Month) (Day) (Year)

7-AGE, ... 32 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Janitor do
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Christian

(Address) 709 Sarah ann St

15- OCT 4 - 1920 ROBERT J. KRAUTER

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct ..... 1 ....., 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull Accidental
Struck by Automobile

(Duration) ..... yrs. a few hours mos. ..... ds.

CONTRIBUTORY (Secondary) Accident

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. X. Gorsuch M. D.
(Coroner.)

10-4, 1920 (Address) 117 N. Paca St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Sharp St C

DATE OF BURIAL, 10-4, 1920

20-UNDERTAKER R C Gross.

ADDRESS 1405 m Ele

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1947021

HEALTH DEPARTMENT—CITY OF BALTIMORE

1947021

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1315 W Saratoga St. 70 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael J. Egan

(Residence in Baltimore: No. 158 Collins Ave. Irvington Str. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE,~~ MARRIED, ~~WIDOWED~~ OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH Sept 16, 1871
(Month) (Day) (Year)

7-AGE. 49 yrs. 0 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Policeman
(b) General nature of industry, business, or establishment in which employed (or employer) 061

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Mose Egan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Bridget McDonnell

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) 158 Collins Ave

(Address) Margaret Egan Wife

15-

Filed OCT 4 - 1920 191 ROBERT E KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 2, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) 4 yrs. 6 mos. ds.

(Signed) John W Curtin M. D.
(Coroner.)

Oct 4, 1920 (Address) 7 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cem. DATE OF BURIAL, Oct 5, 19..

20-UNDERTAKER Margaret E. Flynn ADDRESS 1427 Light St

Spec.—8-24-14—M. & T.—2000 Blks.

D47022

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47022

CERTIFICATE OF DEATH.

82

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Fountain Hgts. 2520 ST.; 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Grove

(Residence in Baltimore: No. 2520 Gwynns Falls Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	single

6-DATE OF BIRTH, Oct 12, 1843
(Month) (Day) (Year)

7-AGE, 76 yrs. 11 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Work
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Jacob Grove

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Miranda Ensor

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Grove

(Address) Johns Hopkins Hos

15- OCT 4 - 1920 ROBERT E KRAUTER
Filed....., 191.....
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 2 1920, to Sept 30 1920, that I saw h alive on 30 Sept 1920, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

cerebral thrombosis

(Duration) yrs. 7 mos. 16 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Samuel Whitehorne M. D.

Sept 30, 1920 (Address) 1342 W Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 7 mos. 16 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Aged Woman Home

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cemetery — DATE OF BURIAL, Oct. 4th, 1920

20-UNDERTAKER C. D. Fanning & Son — ADDRESS 1938 E. Lafayette

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Bellissino

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47023

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47023

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 S. Fremont ST.: VV WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angelina Bellissino

(a) RESIDENCE. NO. 215 S. Fremont ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 14yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Leo. Bellissino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Angelina Guercio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Leo. Bellissino
(Address) 215 S. Fremont St.

15 Filed AUG 4 - 1920 19 ROBERT E KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 27th 1920. to Aug 2nd 1920.

that I last saw h[illegible] alive on Aug 11 1920.

and that death occurred, on the date stated above, at 3:00P m.

The CAUSE OF DEATH* was as follows:

malnutrition

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

[illegible] 19 (Address) 654 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	8/4/ 1920
20 UNDERTAKER George D. Ruth	ADDRESS 1735 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RESERVED FOR BINDING

D 47024

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 47024

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1152 Homestead St. WARD) REGISTERED No. C

(If death occurred in a hospital or Institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Vansant.

(Residence in Baltimore: No. 1152 Homestead St. St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Wht.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Widow

6-DATE OF BIRTH, Dec 29 (Month) (Day), 1833 (Year)

7-AGE, 86 yrs. mos. ds.

If LESS than 1 day, hrs. or min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Homemaker
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Isaac Harris

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary A. Cloman

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Vansant

(Address) 1132 Homestead St

15-

Filed OCT 4 1906, 191 Registrar.

ROBERT B. BRUTER
REGISTRAR OF VITAL STATISTICS

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 1 (Month) (Day) 1906 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. H. Smelley M. D.
Coroner.

(Address) 1132 Homestead St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cemetery

DATE OF BURIAL, Oct 4, 19

20-UNDERTAKER Wm Cook

ADDRESS 502 E Monument

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47025

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 3010 McKay Court ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Leikowski

(a) RESIDENCE. NO. 3010 McKay Court ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

6a If married, widowed or divorced HUSBAND of (or) WIFE of Mary Leikowski

6 DATE OF BIRTH (month, day, and year) July 10 1876

7 AGE Years 44 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of indostry, business, or establishment in which employed (or employer) Steel Works

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Leikowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gabella Gallata

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Leikowski

(Address) 3010 McKay

15 Filed OCT 4 - 1920 ROBERT B KRAUTER Registrar

Burial

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3d 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 29th 1920 to Oct 3d 1920

that I last saw him alive on Oct 3d 1920

and that death occurred, on the date stated above, at 10 5/8 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Schwatka M. D.

, 19 (Address) 734 Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross DATE OF BURIAL Oct 6 20

20 UNDERTAKER WM Wolf ADDRESS Sor Wash

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Henry Treide

1047026 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047026

CERTIFICATE OF DEATH.

1-PLACE OF DEATH: Bellevue Hosp. CITY OF BALTIMORE (No. 9 East St. St. 6 Ward) REGISTERED No. C 29

2-FULL NAME: Henry Theide Sr

(Residence in Baltimore: No. 2402 E Balto St)

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

St. Yrs. mos. ds.

N.B.—THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK—Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: January (Month) 23rd (Day), 1857 (Year)

7-AGE: 63 yrs. 8 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant 045
(b) General nature of industry, business, or establishment in which employed (or employer): Wholesale Underwear Jersey

9-BIRTHPLACE, (State or Country): City

PARENTS.

10-NAME OF FATHER: J. H. G. Treide

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Pagels

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry C. Theide

(Address) 3468 Auchentorlie Terrace

15- OCT 4 - 1920 ROBERT P. KRAUTER

Filed....., 191.. Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Oct. (Month) 2 (Day), 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Wholesale Underwear

(Duration) yrs. mos. ds.

(Signed) H. C. Hurd M. D.
(Coroner)

Oct 2 191.. (Address) 24 E Balto St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery | DATE OF BURIAL, Oct 5 (Day), 19.2

20-UNDERTAKER: Geo. Weber & Son | ADDRESS 2503 Edmondson Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

1947027

HEALTH DEPARTMENT—CITY OF BALTIMORE

1947027

81

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 N. Harford Ave. 1st 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Farrell

(a) RESIDENCE. No. 1700 N. Harford Ave. 1st WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Maggie Farrell

6 DATE OF BIRTH (month, day, and year) Autumn.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Police

(b) General nature of industry, business, or establishment in which employed (or employer) 061

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Matthew Farrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Julia Farrell (Address) 1700 Harford Ave

15 Filed OCT 4 - 1920 19 ROBERT F. SLAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 16 1920, to Oct 1, 1920, that I last saw him alive on Sept 30, 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bright's Disease

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? V

Did an operation precede death? V Date of

Was there an autopsy? No

What test confirmed diagnosis? V

(Signed) Mc Donnell M. D.

10/3, 1920 (Address) 108 N. Sutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Oct 6th 1920

20 UNDERTAKER Martin Fahey & Sons ADDRESS 1827 N. North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

Geneva Robinson

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1047028 | 29 1047028

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1305 E. Monument ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geneva Robinson

(a) RESIDENCE. No 1305 E. Monument ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	B	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of 20

6 DATE OF BIRTH (month, day, and year) Oct 10 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Agustus Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ella Glea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lowell Robinson
(Address) 1305 E. Monument St

15 Filed OCT 4 - 1920 . 19 ROBERT J. KRAUTER Registrar
Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-1 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1920, to Oct 1, 1920, that I last saw h[illegible] alive on Oct 1, 1920, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Labulor Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Inflammatory Tuberculosis (duration) yrs. mos. 07 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. H. Hornstein, M. D.

10/4, 1920 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemetery	Oct 4 1920
20 UNDERTAKER Mrs Robb & Elliott	ADDRESS 226 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D47029 HEALTH DEPARTMENT—CITY OF BALTIMORE D47029

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 20 S. Hare St.) (ST.) (WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Smith.

(Residence in Baltimore: No. 20 S. Hare St.) (St.) 27 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col'd	Married

6-DATE OF BIRTH, Jan (Month) 4 (Day), 1893 (Year)

7-AGE, 40 yrs. 5 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): City Parks

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Jos. Smith

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Ella O Connor

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Smith

(Address) 20 S Hare St

15-

Filed OCT 4 - 1920 191.....

ROBERT B KRAUTER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 1, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Intracalvar Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm Faulkner M. D.
(Coroner.)

10-4 191 20 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	Oct 5, 1920
20-UNDERTAKER	ADDRESS
Peter Nicolaus	2046 East

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47030

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 D47030

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Lincoln & Valley ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Quigley.

(a) RESIDENCE. No Little Sisters of the Poor WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 40 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow of

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Quigley.

6 DATE OF BIRTH (month, day, and year) 8 Jan 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Timothy Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Margaret —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Sister Florence

(Address) Valley & Preston Sts.

15 Filed OCT 4 - 1920 19 ROBERT P. LAMUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 1920 to ..... 19..., that I last saw her alive on Oct 3 1920, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis

3 days (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F A Warner. M. D.

Oct 3 1920 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Cathedral Oct 5- 1920

20 UNDERTAKER — ADDRESS

K. C. Wiedefeld 914 Greenmt Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47031

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47031

CERTIFICATE OF DEATH.

151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 373 S. am ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Frere

(a) RESIDENCE. NO. 373 S. am ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR ~~OR RACE~~	5 Single, Married, ~~Widowed~~, or Divorced (write the word)
F	W	~~Single~~

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
2 hours			

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt
(State or country)

PARENTS

10 NAME OF FATHER Wm Russell

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER ~~Katherine~~ Kate Frere

13 BIRTHPLACE OF MOTHER (city or town) Urbana
(State or country)

14 Informant .....
(Address)

15 Filed OCT 4 - 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1920, to Oct 3, 1920, that I last saw h[er] alive on Oct 3, 1920, and that death occurred, on the date stated above, at Oct 4 ~~P.M.~~ A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth (5788)

(duration) ..... yrs. 2 mos. hrs.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. Wallace, M. D.

Oct 4, 1920 (Address) 1402 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	Oct 4 1920
20 UNDERTAKER	ADDRESS

Commissioner Health.

17045

mation should be carefully supplied. Examine Manual of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 47032

D. 47632

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 1104

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Baker.

(a) RESIDENCE. No. 409 Evesham Ave. Baltimore Md ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4 mths	2 da	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) Catonsville Md
(State or country) Maryland

PARENTS

10 NAME OF FATHER Russell Baker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Penn.

12 MAIDEN NAME OF MOTHER Anne Brittain

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New Jersey

14 Informant J. ttt.
(Address)

15 Filed OCT 4 - 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 28 -, 1920, to Oct 3., 1920, that I last saw h.. alive on Oct 3 -, 1920, and that death occurred, on the date stated above, at 745 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Enteritis (2nd attack)

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. P. Harrison, M. D.

, 19 (Address) 111 E. Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Oct 5 1920
20 UNDERTAKER	ADDRESS
Joseph Ahrens	2210 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.47033

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.4703

CERTIFICATE OF DEATH.

REGISTERED No. C 79

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 646 Redwood st ST.: W WARD)
(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Ferguson
(Residence in Baltimore: No. 646 Redwood St.: 14 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	White	Married

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER, Mahelly
11-BIRTHPLACE OF FATHER (State or Country), Irland's
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (State or Country), Irland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ted Ferguson
(Address) 646 W. Redwood Ave.

15-
Filed OCT 4 1920, 191
Robert P. Harrison,
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 27, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~Inquest, au~~ ~~topsy or inquiry.)~~ find that said deceased came to ~~Her~~ death on the day stated above.
The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart
(Duration) yrs. Don't Know mos. ds.
CONTRIBUTORY (Secondary) Don't Know
(Duration) yrs. 1 mos. 6 ds.
(Signed) W. R. Fordney M. D.
(Coroner.)
9-29, 1920 (Address) 117 W. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Oct 5, 1920
20-UNDERTAKER Joseph B Cook	ADDRESS 1003 N Balto.

Spec. 6-9-19 H. P. Co.—1000 Blks.

D.47034 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47034

CERTIFICATE OF DEATH.

151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3415 E. Fayette ST. 76 WARD)

2-FULL NAME Infant of Knight Anna Hoffmann

(a) RESIDENCE. No. 3415 E. Fayette ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Premature

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 2 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Premature Birth

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Hoffmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chicago, Ill.

12 MAIDEN NAME OF MOTHER Anna Appan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant (Address) Joseph Hoffmann 3411 E. Fayette

Filed OCT 4 - 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2 - , 19 20, to Oct. 2 - , 19 20, that I last saw h in alive on Oct. 2 , 19 20, and that death occurred, on the date stated above, at 5:40 a. m.

The CAUSE OF DEATH* was as follows:

(Premature Birth.
5 months foetus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Allen C. Burkham, M. D.

(Address) 3139 E. Baltimore St. 10-2 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Backmansburn	Oct 4 1920
20 UNDERTAKER	ADDRESS
John A Moran	Balto + Pot

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.47035

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47035

CERTIFICATE OF DEATH.

8-104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 N. Highland Ave ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Melvin Schenning.

(a) RESIDENCE. NO. 28 N. Highland Ave ST. 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 26 - 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	1	10.	

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Albert Schenning

11 BIRTHPLACE OF FATHER (city or town) (State or country) Buffalo N.Y.

12 MAIDEN NAME OF MOTHER Annie Loeffler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Father) (Address) 28 N. Highland Ave.

15 Filed OCT 4 1920 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4th 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 24th 1920 to Oct 3 1920, that I last saw him alive on Oct 3 1920, and that death occurred, on the date stated above, at 8 45 m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) 4 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Partial Enteritis. Rachitis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. Schenning, M. D.

10/4 1920 (Address) 330 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	Oct. 5th 1920
20 UNDERTAKER Lilly & Zeiler	ADDRESS 400 S. Hoffman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47036 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47036

91-089

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 N. Highland Ave ST.; 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Albert Schenning.

(a) RESIDENCE. No. 28 N. Highland Ave ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD AND any omission of information should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 00

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Albert Schenning

11 BIRTHPLACE OF FATHER (city or town) (State or country) Buffalo N.Y.

12 MAIDEN NAME OF MOTHER Annie Loeffler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Albert Schenning.

(Address) 28 N. Highland Ave.

15 Filed OCT 4 - 1920. Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2nd 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1920, to Oct 2, 1920, that I last saw h.. alive on Oct. 2, 1920, and that death occurred, on the date stated above, at 5 15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) H. D. Chrisler, M. D.

Oct 2. 1920 (Address) 330 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem.

DATE OF BURIAL: Oct 5 1920

20 UNDERTAKER: Lilly & Zeller

ADDRESS: 403 S. Wolfe St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47037 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47037

104

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PLACE OF DEATH should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 Glyndon ave ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olga E. Urbanic

(a) RESIDENCE. NO. 1312 Glyndon Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 22, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Matthi Urbanic

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria Hungary

12 MAIDEN NAME OF MOTHER Martha Domicko

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Matthias Urbanic 1312 Glyndon ave

15 Filed OCT 4 1920 Robert P. Harrison, Registrar

(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 25 1920 to Oct 4 1920 that I last saw him alive on Oct 4 1920 and that death occurred, on the date stated above, at 6.30A m.

The CAUSE OF DEATH* was as follows:

Cerebral Congestion

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

Oct 4 1920 (Address) 835 Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Oct. 6 1920
20 UNDERTAKER	ADDRESS
Mr. Mrs John W Temple	501 N Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D.47038 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47038

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern Hospital ST.; 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby. Webb.

(Residence in Baltimore: No. 2532 Greenmount Ave St.; ..... yrs., ... mos. 1 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	—

6-DATE OF BIRTH, Oct 2, 1920
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 1 ds. If LESS than 1 day, 24 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Southern Hospital Baltimore, Md

PARENTS.

10-NAME OF FATHER, John Webb

11-BIRTHPLACE OF FATHER (State or Country), Knoxville Tennessee

12-MAIDEN NAME OF MOTHER, Pauline Hope

13-BIRTHPLACE OF MOTHER (State or Country), Knoxville Tennessee

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pauline Webb

(Address) Southern Hospital

15- Robert P. Harrison,

Filed OCT 4 1920, 191.....

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 3, 3, 1920.
(Month) (Day)

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 1920, to Oct 3 1920, that I saw h in alive on Oct 3 1920, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

of Mother (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) W. A. Wilson Dailey M. D.

Oct 4, 1920. (Address) 1611 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. One ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Wash Hampden	Oct 5..., 1920.
20-UNDERTAKER	ADDRESS
J Walter Davis	3307 Paine St

Spec.—6-9-19—H. P. Co.—1000 Pks.

D.47039 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47039

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 N. Gilmor ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmira Bassett.

(a) RESIDENCE. No. 22 N. Gilmor ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE of DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed or divorced
HUSBAND of (or) WIFE of Freeman D. Bassett.

6 DATE OF BIRTH (month, day, and year) Oct. 15. 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tuscaloosa N J

PARENTS

10 NAME OF FATHER Wm Cavesh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Augusta Maine

12 MAIDEN NAME OF MOTHER Mary Wrackwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cape May N J

14 Informant Mrs Rose a Freeburger
(Address) 22 N Gilmor

Burial Permit

15 Filed OCT 4 1920, 19 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1920, to Oct 3, 1920, that I last saw h[er] alive on Oct 3, 1920, and that death occurred, on the date stated above, at 6.30 P.m.

The CAUSE OF DEATH* was as follows:

Duodenal ulcer ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis 8 hours

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) S. Theo Wedemeyer M. D.

Oct. 19 20 (Address) 34 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery.	Oct 6 1920
20 UNDERTAKER Bertram B Gorter	ADDRESS 1753 W Lafayette

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 47040 ✓ D. 47040

HEALTH DEPARTMENT—CITY OF BALTIMORE

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2908 Reed ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Kernan

(a) RESIDENCE. No. 2908 Reed ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day 2½ hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Eugene J. Kernan

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Ella May Gantrie

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md

14 Informant E. J. Kernan
(Address) 2631 Calvert st

15 Filed OCT 4 1920 . 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 19 20

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 19 20, to Oct 4, 19 20

that I last saw him alive on Oct 4, 19 20

and that death occurred, on the date stated above, at 9 30 a m.

The CAUSE OF DEATH* was as follows:

7 mo fetus

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) asphyxia neonatorum

(duration) yrs. 2 hours mos. ds

18 Where was disease contracted if not at place of death? 2908 Reed st

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physician

(Signed) H. W. Kernan, M. D.

, 19 (Address) 263 Calvert st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemt.

DATE OF BURIAL Oct 5th 20

20 UNDERTAKER Putnam & Gove

ADDRESS 1923 N Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1047041 ✓ 1047041

X129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. South Balto General Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sewell

(a) RESIDENCE. NO. Fredericktown, Md. Cecil Co. Fredericktown

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 10 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cecil Co. Md.

PARENTS

10 NAME OF FATHER Andrew Sewell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cecil Co. Md.

12 MAIDEN NAME OF MOTHER Annie Farlane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cecil Co. Md

14 Informant Andrew Sewell (Address) Belton Texas but dont know

15 Filed OCT 5 - 1920 [illegible] KRAUTER Registrar

Burial Permit Oct 5

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1920, to Oct. 1, 1920, that I last saw her alive on Oct. 1, 1920, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

{Chronic Pelvic Inflammatory Disease
Fibroids
Operation Long time.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 9-24-20

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) C. B. Dawson M. D.

, 19 (Address) 513 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Oct 5 1920
20 UNDERTAKER N. L. & Brown & Son	ADDRESS 1011 W. Mont

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. ANY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

947042 HEALTH DEPARTMENT—CITY OF BALTIMORE 947042

CERTIFICATE OF DEATH. 138

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2714 Winchester ST., 16 WARD)

2-FULL NAME Mary Starry

(a) RESIDENCE. NO. 2714 Winchester ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. S. Starry

6 DATE OF BIRTH (month, day, and year) Jany 15-1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31 yrs	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles Haddock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Annie Hoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Thomas J. Starry
(Address) 2714 Winchester St

15 Filed OCT 5 - 1920 ROBERT F. LEACH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1920, to Oct 3, 1920, that I last saw h[illegible] alive on Oct 3, 1920, and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 8 hrs

CONTRIBUTORY (Secondary) Fatty Degeneration of Heart

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) M. A. O'Neill, M. D.

10/4. 1920 (Address) 108 N. Sutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	10/6 1920

20 UNDERTAKER J. A. Brown ADDRESS 3000 E. Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D47043 HEALTH DEPARTMENT—CITY OF BALTIMORE D47043

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1814 Ettings ST. 14 WARD) 29

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph T. Brown

(Residence in Baltimore: No. 1814 Ettings St.) 20 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, November 25, 1875
(Month) (Day) (Year)

7-AGE, 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Annapolis Maryland

PARENTS.

10-NAME OF FATHER, William Brown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Brown

(Address) 1814 Ettings Ave

15- OCT 5 - 1920 ROBERT B. KRAUTER

Filed ....., 191.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 2, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) see history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

October 2, 1920 (Address) 1802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Mt. Calvary Cem. DATE OF BURIAL, Oct 5, 1920

20-UNDERTAKER Samuel Kennedy ADDRESS 578 W Baltimore

D 47044 HEALTH DEPARTMENT—CITY OF BALTIMORE. D 47044

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 933 E Clinton St.; 26 WARD) REGISTERED No. C 104

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Taylor Jr.

(Residence in Baltimore: No. 933 E Clinton St St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, March 6 (Month) — (Day), 1920 (Year)

7-AGE, ...yrs. 6 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child (boy)
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, William E Taylor

11-BIRTHPLACE OF FATHER (State or Country), Balto City

12-MAIDEN NAME OF MOTHER, Amelia Leamon

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William E. Taylor

(Address) 933 So Schroeder St

15- OCT 5 - 1920 BUREAU OF VITAL STATISTICS

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) — 4 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) ....yrs. ....mos. ....ds.

(Signed) Jno. L. Blades M. D.
(Coroner.)

10/4/20 (Address) 1727 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount — DATE OF BURIAL, Oct 5, 1920

20-UNDERTAKER Lilly & Zeller — ADDRESS 403 So Wolfe

D47045 HEALTH DEPARTMENT—CITY OF BALTIMORE D47045

CERTIFICATE OF DEATH.

175-009

1-PLACE OF DEATH

CITY OF BALTIMORE (No. South Baltimore General Hospital WARD) 12

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME H.Vernon Amey.

(Residence in Baltimore: No. 1747 Hanover St. St.; 7 yrs., 5 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, April 9th, 1913, 1
(Month) (Day) (Year)

7-AGE, 7 yrs. 5 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None. 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Edgar F. Amey.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Martha E. Brom.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar F. Amey (father)

(Address) 1747 Hanover St.

15-

Filed ....., 191. ROBERT P. LAMDIN Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 3rd. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the Skull.
Accidentally struck and run over by Automobile. License #81768.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto F. Reinhardt M. D.
(Coroner.)

Oct. 4th., 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Hanover near Barney Sts.

Former or usual residence 1747 Hanover St.

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Oct. 5, 1920

20-UNDERTAKER F. C. Kramer & Son. — ADDRESS 703 Hanover St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47046

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47046

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724 Brentwood Ave ST. 10 WARD)

REGISTERED NO. 1720

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James W. Kocher.

(a) RESIDENCE. No. 1724 Brentwood ave WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced BUSBAND of (or) ~~WIFE~~ of Mary Kocher

6 DATE OF BIRTH (month, day, and year) Dec 21 - 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Officer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Custom House

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER George W. Kocher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Ella J. Dice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary Kocher

(Address) 1724 Brentwood Ave

15 Filed OCT 5 - 1920 19 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 3rd 1920.

17 I HEREBY CERTIFY, That I attended deceased from November, 1919, to October 3rd, 1920, that I last saw him alive on Oct. 2nd 9am, 1920, and that death occurred, on the date stated above, at 4.35 A m.

The CAUSE OF DEATH* was as follows:

Nephritis,

(duration) 1+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer, Bronchopneumonia,

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At the place of death

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Chemical & Microscopic

(Signed) Wilbur Brinton, M. D.

, 19 (Address) S W. Cor. Eutaw & Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Oct 5th 1920

20 UNDERTAKER William Cook

ADDRESS 509 E Lan ave

N. B.—WORDS printed in SMALL CAPITALS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47047 D47047

CERTIFICATE OF DEATH.

X 104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 E. 35th ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Orris Howard Joyce.

(a) RESIDENCE. NO. 415 E. 35th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 31 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Va.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 33 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cape Charles - Va.

PARENTS

10 NAME OF FATHER Howard P. Kellam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Gail Joyce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Howard P. Kellam
(Address) 415 E. 35th St

15 FILED OCT 5 - 1920 ROBERT B KRAUTER Registrar

Burial Permit Oct 6

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4th 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1920, to Oct 4, 1920, that I last saw h[illegible] alive on Oct 4, 1920, and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Enterocolitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 1107 Lexington Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine	Oct 6 1920
20 UNDERTAKER William Cook	ADDRESS 502 E Hall Ave

A. B. MARK PLAINLY, with pen and ink. All questions must be fully answered. If unknown, or if the question is not applicable, a dash (—) should be written. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D 47048

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47048

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH Buddle & Gillespie Hosp. REGISTERED NO. C

CITY OF BALTIMORE: (No. 2724 N Charles St. 17 ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvina Harris

(Residence in Baltimore: No. 2724 N Charles St St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... June (Month) 7 (Day) ....., 1920 (Year)

7-AGE, ... yrs. 4 mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore city

PARENTS.

10-NAME OF FATHER, Harry Morris

11-BIRTHPLACE OF FATHER (State or Country), Mississippi

12-MAIDEN NAME OF MOTHER Ethel Harris

13-BIRTHPLACE OF MOTHER (State or Country), Cambridge Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ethel Harris

(Address) 2724 N Charles St

15-

Filed ..... 191.....

ROBERT P. FLANNERY
DEPUTY REGISTER

OCT 5 - 1920

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct (Month) 3 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 19th 1920, to Oct 3 1920

that I saw h-- alive on Oct 30th 1920,

and that death occurred, on the date stated above, at 7 p.m.

The CAUSE OF DEATH* was as follows:

Pulm. Tuberculosis

(Duration) ..... yrs. ..... mos. 2 1 ds.

CONTRIBUTORY (Secondary) Mal Nutrition

(Duration) ..... yrs. ..... mos. 2 1 ds.

(Signed) H. H. Bradley M. D.

Oct 4, 1920 (Address) 2724 N Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross DATE OF BURIAL, Oct 5, 1920

20-UNDERTAKER Lowbook ADDRESS 50 E. Lanvale

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 47049

CERTIFICATE OF DEATH.

282 47049

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2404 Woodbourne Ave ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta R. Clayton

(a) RESIDENCE. No. 2404 Woodbourne ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hezekiah Clayton

6 DATE OF BIRTH (month, day, and year): April 7, 1846

7 AGE: Years 74 Months 6 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Henry Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penn.

12 MAIDEN NAME OF MOTHER: Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: Dr. R. Clayton

(Address): 2404 Woodbourne Ave

15 Filed OCT 5 - 1920 . 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct-4 1920

17 I HEREBY CERTIFY, That I attended deceased from August 5, 1920, to Oct. 4, 1920, that I last saw h[illegible] alive on Oct 3, 1920, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Oliver S Lloyd M. D.

. 19 (Address) 2232 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: B. Ldinn

DATE OF BURIAL: Oct-6 1920

20 UNDERTAKER: Wm Cook

ADDRESS: Wash Blvd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DARK

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47050

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47050

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4909 Crowson Ave ST.: Gorsuch WARD)

2-FULL NAME Garzia R Balt

(a) RESIDENCE. No. 4909 Crowson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Randolph Balt

6 DATE OF BIRTH (month, day, and year) Nov 25/854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	10	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher 68

(b) General nature of industry, business, or establishment in which employed (or employer) City Schools

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) Baltimore Co
(State or country) Maryland

PARENTS

10 NAME OF FATHER Caleb Royston

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sophia Lowe

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mary R Tiler
(Address) 4909 Crowson Ave

15 Filed OCT 5 - 1920 19 ROBERT A KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4th 1920

17 I HEREBY CERTIFY, That I attended deceased from July 26th 19 20, to Oct 4th 1920, that I last saw h[illegible] alive on Oct 3rd 1920, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Hemiplegia and
Central Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 36 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Daniel Balt M. D

19 (Address) 1376 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 6 1920
20 UNDERTAKER	**ADDRESS**
Lemmon & Co	502 E Hartford

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Emmy Carroll.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47057 — 42 D47051

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2741 Freemont Ave. St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emmy Carroll

(Residence in Baltimore: No. 2741 Freemont Ave St.; 15 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6-DATE OF BIRTH: May 9, 1854 (Month) (Day) (Year)

7-AGE: 66 yrs. 5 mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 637

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Thomas Cleaves

11-BIRTHPLACE OF FATHER (State or Country): Maine

12-MAIDEN NAME OF MOTHER: Emma M. Cleaves

13-BIRTHPLACE OF MOTHER (State or Country): Maine

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph T. Carroll

(Address) 2741 Freemont Ave

15- OCT 5 - 1920 Filed ....., 191. ROBERT B KRAUTER Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: October 5th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 10th 1920, to Oct 5th 1920, that I saw her alive on Oct 5th 1920, and that death occurred, on the date stated above, at 1.15 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

..... (Duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus

..... (Duration) 6 yrs. ... mos. ... ds.

(Signed) Geraldine Stahlman M. D.

Oct 5th, 1920 (Address) 401 E 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL, Oct 7, 191.

20-UNDERTAKER: William Cook — ADDRESS 502 S. Hall St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D47052

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47052

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 1514 Division ST.; 14 WARD)

REGISTERED NO. C 1082

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Annie Stubbs.

(Residence in Baltimore: No. Union memorial Hospital St.; ..... yrs., ... mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, November 30 (Month) (Day), 1857 (Year)

7-AGE 63 yrs. 10 mos. 5 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph Swindle

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sara Stubbs

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). S. N. Holden

(Address) Delta. Pa.

15- OCT 5 - 1920 Filed ....., 191.... ROBERT P. KRAUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 5th (Month) (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 30 1920, to October 5th 1920, that I saw her alive on October 5th 1920, and that death occurred, on the date stated above, at 2:15 a.m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix with General Peritonitis

(Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Intestinal obstruction (?)

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) J. M. Timanus M. D.

Oct. 5, 1920. (Address) Union Memorial Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 6 ds. In the State ..... yrs. ..... mos. 6 ds.

Where was disease contracted, if not at place of death? At home

Former or usual residence Delta, Pa.

19-PLACE OF BURIAL OR REMOVAL, Slate Ridge Pa. DATE OF BURIAL, Oct 7, 1920

20-UNDERTAKER H J Tecknor ADDRESS Jarrettsville Md

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1947053 HEALTH DEPARTMENT—CITY OF BALTIMORE 1947053

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH St. Joseph's Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Caroline & Oliver ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bolesław Chiojnowski

(a) RESIDENCE. No. 807 Ann ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: single

6 DATE OF BIRTH (month, day, and year): Sep 25 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	—	9	

8 OCCUPATION OF DECEASED 040

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer): Boiler Shaler

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Paul Chojnowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Frances Ruthowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Aleksander Chojnowski
(Address): 802 Linden Ave

15 Filed OCT 5 1920, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1920 to Oct 4, 1920

that I last saw him alive on Oct. 4, 1920

and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. C. Marucci, M. D.

19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 6 1920

20 UNDERTAKER: John A. Weber

ADDRESS: 1803 Bank St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Luczkowski

1047054 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047054

64

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1623 Shakespeare St. V WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Luczkowski

(Residence in Baltimore: No. 1623 Shakespeare St. St.: yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female
4-COLOR OR RACE: White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: March 5 1850, 1
(Month) (Day) (Year)

7-AGE: 70 yrs. 6 mos. 24 ds.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Poland

PARENTS.
10-NAME OF FATHER, Jacob Kaleski
11-BIRTHPLACE OF FATHER (State or Country): Poland
12-MAIDEN NAME OF MOTHER: Mary ?
13-BIRTHPLACE OF MOTHER (State or Country): Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Anthony Luczkowski
(Address): 1623 Shakespeare St

15- ROBERT B KRAUTER
Filed OCT 5 - 1920 191.... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 3, 19..
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

Signed Henry Gray Post M. D.
(Coroner)
Oct 5 1920 (Address) 1804 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Oct 6, 1920
20-UNDERTAKER John A Weber — ADDRESS 1803 Bank St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47055 HEALTH DEPARTMENT—CITY OF BALTIMORE D47055

CERTIFICATE OF DEATH. 30

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1505 Pressman ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernestine E. Jones

(a) RESIDENCE. NO. 1505 W. Presstman ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Child.

6 DATE OF BIRTH (month, day, and year) Aug. 26 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (Child) 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Jerome Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Wormley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Lydia Courtz 1505 W Pressman

15 Filed ... 1920 ... Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 18 1920 to Oct 3 1920 that I last saw her alive on Oct 1 1920 and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculer Meningitis

(duration) — yrs. — mos. 29 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Fle. Lenk, M. D.

(Address) 313 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 5. 1920

20 UNDERTAKER Edw. Ringgold ADDRESS 1437 N. Gay St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1047056 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047056

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE (No. South Baltimore General Hospital WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Dobrowolskie.

(Residence in Baltimore: No. 1345 Richadrson St.)

26 ---------- (St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male.	White.	Married.

6-DATE OF BIRTH, ... Do not know. (Month), ... (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
54 yrs. ---------- mos. ---------- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 074

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Smulski.

(Address) 1345 Richadrson St.

15- Filed OCT 5 - 1920, 191.... ROBERT B. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... October 1st, 1920 (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autpsy & Inqry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autps (Inquest, autopsy or inquiry.) & Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Acute Lobar Pneumonia.

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Henry Reinhardt M. D. (Coroner.)

Oct. 5th., 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oakhill	Oct 6, 1920
20-UNDERTAKER Zimmler & Zirkler	ADDRESS 1739 E. Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047057

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047057

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Wilkins Ave ST. 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Doyle

(a) RESIDENCE. No. 530 S Fulton Ave ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Wm E Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila Pa

12 MAIDEN NAME OF MOTHER Geo anna Kirby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Wm E Doyle
(Address) 530 S Fulton Ave

15 Filed OCT 5 — 1920 ROBERT E KRAUSE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1920, to Oct 4th, 1920, that I last saw him alive on Oct 4th, 1920, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) W M Craig, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Oct 5 1920
20 UNDERTAKER	ADDRESS
Robt Brookhart	178 Calhoun

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.47058 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47058

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 427 Druid Hill Ave ST. H WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Hutchins

(Residence in Baltimore: No. 427 Druid Hill Ave. St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, August 4, 1892
(Month) (Day) (Year)

7-AGE, 28 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter 086
(b) General nature of industry, business, or establishment in which employed (or employer): (Hotel Asst)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jennie Butler

(Address) 427 Druid Hill Ave.

15-

Filed OCT 5 1920, 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 5, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) and Senility

(Duration) yrs. 1 mos. ds.

(Signed) C. J. Hemmeter M. D.
(Coroner.)

October 5, 1920 (Address) 2802 Eutaw Place, 6th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL,
Mt. Auburn Cemetery	Oct. 4, 1920
20-UNDERTAKER John W. Johnson	ADDRESS 1234 Eutaw St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.4705-9 HEALTH DEPARTMENT—CITY OF BALTIMORE D47059

CERTIFICATE OF DEATH.

99

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Preston & Valley Sts. ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Simpsoon

(a) RESIDENCE. No. Little Sisters of the Poor ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	B. Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single 1828

6 DATE OF BIRTH (month, day, and year) ~~25 Oct 1920~~.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	92			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None ppd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Edward Simpsoon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Jane Tender.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Sister Florence.
(Address) Little Sisters of the Poor

15 Filed OCT 5 1920 16 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1920

17 I HEREBY CERTIFY, That I attended deceased from to record
, 19 , to , 19 ,
that I last saw her alive on Oct 3 , 1920,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Val. Disease of heart
Unknown (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Dropsy
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? I don't know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

Oct 6 1920 Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Oct 6 1920

20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Fremont Ave.

mation should be carefully supplied. A DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact [illegible] OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47060

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47060

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 N Appleton ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dellia Cheeseman

(a) RESIDENCE. NO. 917 N Appleton ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 7 mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Varon S Cheeseman

6 DATE OF BIRTH (month, day, and year): Nov 10 1883

7 AGE: Years 37 Months 11 Days

If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Farington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Varon S Cheeseman 917 N Appleton St

15 Filed ..... 19..... Registrar

OCT 3 - 1920

Robert F. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 5 1920

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1920, to Oct. 5, 1920, that I last saw h.e alive on Oct. 4, 1920, and that death occurred, on the date stated above, at 8 30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about (duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? don't know

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Martin Dean M.D.

10. 5. 1920 (Address) 413 Prof. Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Oct 8 1920

20 UNDERTAKER: Wm Tuck & Co — ADDRESS: 502 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47061

CERTIFICATE OF DEATH.

40 D 47061

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1268 James - ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. F. Liggett

(Residence in Baltimore: No. 1268 James — St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. March 20, 1873. (Month) (Day) (Year)

7-AGE. 47 yrs. 6 mos. 15 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Stock Keeper
(b) General nature of industry, business, or establishment in which employed (or employer). 611

9-BIRTHPLACE, (State or Country). Washington D.C.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William M. Liggett

(Address) 1268 James St

15- Robert P. Harrison,

Filed OCT 5 - 1920, 191.... Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 4, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 14 1920, to Oct 4 1920, that I saw h— alive on Oct 4 1920, and that death occurred, on the date stated above, at 1.00 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) yrs. 2 mos. — ds.

(Signed) Edw. Grampton M. D.

Oct 5, 1920. (Address) 217 Hoff

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Western	Oct 9, 1920.
20-UNDERTAKER William Cook	ADDRESS 5021 Hall Co.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47062 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47062

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2110 W. Baltimore St ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Gelbach.

(a) RESIDENCE. No. 2110 W. Baltimore St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fairfield Pa.

PARENTS

10 NAME OF FATHER Joseph Gelbach.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Eliza Roffensberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Mary Ware Penn. (Address) 2110 W. Baltimore St

15 Filed , 19 , Registrar

OCT 5 - 1920

[Robert P. Harrison
Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1918, to Oct 3, 1920, that I last saw him alive on Oct 2, 1920, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. Unknown mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Walter A Cox, M. D.

, 19 (Address) 54 Tuxton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Glen Rock. Pa	Oct 6 1920
20 UNDERTAKER	ADDRESS
George L. Schwab & Bro	2101 Eutaw Pl

mation should be carefully supplied. AGE should be stated EXACTLY. If [illegible]
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Stricker)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47063 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47063

CERTIFICATE OF DEATH.

6-7-1

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 214 S. ~~Monroe St~~ ST.; 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William S Stricker

(a) RESIDENCE. NO. 214 S. Monroe St ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 10 mos. 25 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Stricker

6 DATE OF BIRTH (month, day, and year) Nov 8, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician 079

(b) General nature of industry, business, or establishment in which employed (or employer) Balto City Fire dept.

(c) Name of employer Balto.

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Edward S Stricker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mary M. Stricker 214 S. Monroe St

15 Filed OCT 5 - 1920 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 24, 1920, to Oct 3, 1920, that I last saw h alive on Oct 3, 1920, and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage —

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. W. Martindale, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Oct 7 1920
20 UNDERTAKER	ADDRESS
Geo L. Schmidt & Bro	710 Eutaw Ave

mation should be carefully supplied. AGE should be stated EXACTLY in YEARS, MONTHS and DAYS. If under 1 year, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47064 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D. 47064

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2331 Madison Ave ST.: 13 WARD)

REGISTERED NO. 47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frida Stern

(a) RESIDENCE. No. 2331 Madison Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Stern

6 DATE OF BIRTH (month, day, and year) Sept 30th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Marcus Durbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant J Stern
(Address) 2331 Madison Ave

15 Filed OCT 5 - 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4th 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 1920, to Oct 1920, that I last saw h[illegible] alive on Oct. 4th 1920, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) oedema of Legs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) I Frederick Lentz, M. D.

10/5, 1920 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	Sept 6th 1920

20 UNDERTAKER Henry Sonneborn ADDRESS 111 W Mt St

mation should be carefully supplied. AGE should be stated EXACTLY. If LESS than a day, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47065 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47065

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST.: 4 WARD) 10th

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Payne

(a) RESIDENCE. NO. Cambridge Md ST., ... WARD. Cambridge Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28th 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (Infant) ooo

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Cambridge
(State or country) Maryland

PARENTS

10 NAME OF FATHER P. P. Payne

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Stovall

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. Ruth S. Payne
(Address) Cambridge, Md.

15 Filed ..... 19 ..... Robert P. Harrison
Registrar

OCT 5 - 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/5 1920

17 I HEREBY CERTIFY, That I attended deceased from 9/30/20, 1920, to 10/5/, 1920

that I last saw h.. alive on 10/5/, 1920

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Chronic intestinal indigestion.

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Inanition

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Chas R. Goeckeritz, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge, Md.	Oct. 5 1920
20 UNDERTAKER Horace Burgee & Son	ADDRESS 631 Fulton

INSTRUCTIONS.—WRITE plainly. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Information on back of certificates. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.47066 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47066

CERTIFICATE OF DEATH.

1700

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 774 Mc Henry ST.; 21 WARD)

2-FULL NAME Alvesda. L. Pfaffenbach

(a) RESIDENCE. No. 774 McHenry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~single~~, Married, ~~Widowed, or Divorced (write the~~ word)
Female	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William Pfaffenbach

6 DATE OF BIRTH (month, day, and year) Feb 12 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford County md

PARENTS

10 NAME OF FATHER Elias Pettinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford County md

12 MAIDEN NAME OF MOTHER Margaret Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co md

14 Informant William Pfaffenbach
(Address) 774 Mc Henry st

15 Filed OCT 5 - 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1920, to Oct 4, 1920, that I last saw h.. alive on Oct 4, 1920, and that death occurred, on the date stated above, at 11 35 P m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Uraemia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam

(Signed) Robert W. Mifflin, M. D.

, 19 (Address) 1016 Madison st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 7 1920
20 UNDERTAKER	ADDRESS
Jos Joerdens & Son	2178 Pen

mation should be carefully supplied. Any ... it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.47067

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

79

D.47067

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 Arlington ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruby Allen Barnes

(Residence in Baltimore: No. 507 Arlington Av St.; 2 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: December (Month) 30 (Day) 1865 (Year)

7-AGE: 54 yrs. 9 mos. 3 ds. If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: John H. Cross

11-BIRTHPLACE OF FATHER (State or country): Balto. Co.

12-MAIDEN NAME OF MOTHER: Sarah Allen

13-BIRTHPLACE OF MOTHER (State or country): Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles E Barnes

(Address) 507 Arlington Ave

15- OCT 5 - 1920 191... Robert P. Harrison, Registrar

Burial Permit ...

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: October (Month) 3 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 28, 1915, to, October 3, 1920, that I saw h.er alive on October 3, 1920, and that death occurred, on the date stated above, at 10:40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) 5 yrs — mos — ds.

Contributory (SECONDARY)

(Duration) ... yrs ... mos ... ds.

(Signed), C D Straughen M. D.

October 4, 1920 [Address] 3949 Freemount Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL: Oct 6, 1920

20-UNDERTAKER: D E Hughes

ADDRESS: 17 S Broadway

Spec.—8-24-14—M. & T.—2000 Bks.

D.47068 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47068

CERTIFICATE OF DEATH.

9 1/2

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child's Hospital St.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Blanche Buggeln

(Residence in Baltimore: No. Nursery & Child's Hospital 3302 Chestnut Ave. St.; ..... yrs., ... mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, March 22, 1920
(Month) (Day) (Year)

7-AGE, ... yrs. 6 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Lawrence Buggeln

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Evelyn Shipley

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Evelyn Buggeln

(Address) 3302 Chestnut Ave

15- Robert P. Harrison,

Filed OCT 5 1920, 191..... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 4, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 30 1920, to Oct 4, 1920 that I saw h[illegible] alive on Oct 4, 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (Duration) .....yrs. .....mos. 4 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) L. F. Tenglemann M. D.

Oct. 4, 1920 (Address) 210 E. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 12 ds. In the State ..... yrs. 6 mos. 12 ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 3302 Chestnut Ave

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden — DATE OF BURIAL, Oct 6, 1920

20-UNDERTAKER Chenowith & Son — ADDRESS 1600 Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47069 D47069

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Tillie Gammerman.

(Residence in Baltimore: No. 16 N. Pine St St.; 24 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1854 (Year)

7-AGE, 26 yrs. ... mos. ... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... House Work
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Bernard Adler

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Fannie Miller

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hebrew

(Address) 1411 E. Baltimore St

15- ROBERT B. BRAUTER

Filed OCT 6 1920 191.. ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 4th 4 am. (Month) (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1920, to Oct. 4 1920, that I saw her alive on Oct. 4 1920, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Subacute Bacterial Endocarditis

(Duration) ... yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(Duration) ... yrs. ... mos. 5 ds.

(Signed) ..... M. D.

Oct. 4, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. 3 mos. 3 ds. In the State 17 yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 16 W Pine St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Washington Rd DATE OF BURIAL, Oct 5, 1920

20-UNDERTAKER Jack Levin ADDRESS 1411 E. Balto.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047070

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047070

CERTIFICATE OF DEATH.

50

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 S Bayard ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Justine Weber

(a) RESIDENCE. No. 120 S Bayard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sept 14 1878

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Vincent Stadler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Stadler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Weber (Address) 1200 Bayard Street

15 Filed OCT 6 — 1920 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1920

17 I HEREBY CERTIFY, That I attended deceased from 1917, 19..., to Oct 5, 1920, that I last saw h[illegible] alive on Oct 5, 1920, and that death occurred, on the date stated above, at 11.40 p m.

The CAUSE OF DEATH* was as follows:

Gangrene of Spine & Hips

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes & Paralysis.

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen d Drain, M. D.

, 19 (Address) 1227 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	10/8/20
20 UNDERTAKER	ADDRESS
Ruello Sons	1724 W Pratt

REGISTRAR SHOULD BE CAREFULLY SUPPLIED. AGE, OCCUPATION, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D47071 HEALTH DEPARTMENT—CITY OF BALTIMORE D47071

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1052 Ruborg St.; 18 WARD) REGISTERED No. C 120

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Johnson

(Residence in Baltimore: No. 1052 Ruborg St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Fem	col	Married

6-DATE OF BIRTH, Sept. (Month) 28 (Day), 1843 (Year)

7-AGE,	If LESS than 1 day,
77 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Ø

9-BIRTHPLACE, (State or Country), Annapolis Md

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country) Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country) Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Lanvale ave

15- OCT 6 - 1920 Filed....., 191.... ROBERT B. BRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 4 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 30 1920, to Oct. 4 1920, that I saw h[er] alive on Oct. 4 191..., and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

1. Chr. Interstit. Nephritis

.....

..... (Duration) yrs. 20 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) yrs. mos. 2 ds.

(Signed) [illegible] M. D.

1076, 191.. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn Cem	Oct. 6, 1920
20-UNDERTAKER Daniel Easton	ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

2047072 HEALTH DEPARTMENT—CITY OF BALTIMORE 2047072

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1217 N. Eden St. ST.: 10 WARD)

REGISTERED No. C 64

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary M. Staacke

(Residence in Baltimore: No. 1217 Eden St. St. yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Widowed

6-DATE OF BIRTH, Oct (Month) 23 (Day), 1861 (Year)

7-AGE	If LESS than 1 day,
58 yrs. 11 mos. 11 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Gabel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Rosch

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. H. Staacke

(Address) 1217 N. Eden St

15- OCT 6 - 1920 ROBERT J. BRAUTER Registrar

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 4 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy,

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) Wm. Finlay M. D.
(Coroner.)

10-5-20, 1920 (Address) 4 E. Lex St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem.	Oct 5, 1920
20-UNDERTAKER	ADDRESS
H. Sander Sons	1210 Hull St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47073 HEALTH DEPARTMENT—CITY OF BALTIMORE D47073

47

CERTIFICATE OF DEATH.

1-PLACE OF DEATH So. Balto. Gen. Hospl REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Elizabeth Schenk.

(a) RESIDENCE. No. 1512 E. Balto. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew H. Schenk.

6 DATE OF BIRTH (month, day, and year) Feb. 11 - 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Paul P. Beettner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Sophie Beil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Andrew H. Schenk. (Address) 1512 E. Balto. St.

15 Filed OCT 6 - 1920 ROBERT P. ELLERBE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1920. to Oct. 4, 1920. that I last saw her alive on Oct. 4, 1920. and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

11 wks. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral embolism

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ——

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. P. Ponte Jr. M. D.

. 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Oct 8 19
20 UNDERTAKER	**ADDRESS**
H. Sander's Sons	1710 Mad St.

BURIAL PERMIT ISSUED

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047074 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047074

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3107 Foster Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Steinmetz

(a) RESIDENCE. NO. 3107 Foster Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 21, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Steinmetz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Laura Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant John Steinmetz
(Address) 3107 Foster Ave.

15 Filed ..... 19.....

OCT 6 - 1920 ROBERT B. KRAUS Registrar

Not a Permit Order

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1 1920 to Oct. 5 1920, that I last saw alive on Oct 5 1920, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Tetanus Infantum

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Otitis Externa

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C S Allen, M. D.

(Address) 408 S Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Swartzbury Cemetery	Oct 6 1920
20 UNDERTAKER	ADDRESS
H. Sander & Son	1705 Fleet St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Tetanus

Sudowdroky

1047075 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047075

CERTIFICATE OF DEATH. 159

(PLACE OF DEATH

CITY OF BALTIMORE (No. Palace Heath, Forsyth & Lafty ST.: 1 WARD) (If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wasil Sudowdroky.

(Residence in Baltimore: No. 6020 S. Eastan- St.: yrs., mos., ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Dont Know, 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
25 about yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer 19
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Kozimowski

(Address) 1235 S. Ducker St

15- OCT 6 - 1920 ROBERT F. HEALTH

Filed ....., 191... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 4, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: from a bullet wound in his left breast fired from a pistol in his own hands - a few minutes (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Suicide (Duration) yrs. a few minutes mos. ds.

(Signed) H. K. Samuel M. D. (Coroner.)

Oct 5 1920 (Address) 112 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Druid Hill Cem -	Oct 6, 1920
20-UNDERTAKER,	ADDRESS
Stephen P. Gialousis	Dont Know

Spec.—8-24-14—M. & T.—2000 Blks.

1947076 HEALTH DEPARTMENT—CITY OF BALTIMORE 1947076

28

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 Woodley ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie Jackson

(Residence in Baltimore: No. 820 Woodley St. St. 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. Sept 5 (Month) (Day), 1897 (Year)

7-AGE. 23 yrs. 1 mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Co Md

PARENTS.

10-NAME OF FATHER. Wm D. Jackson

11-BIRTHPLACE OF FATHER (State or Country). Balto Co Md.

12-MAIDEN NAME OF MOTHER Mary E Hale

13-BIRTHPLACE OF MOTHER (State or Country). Balto Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm D Jackson

(Address) 820 Woodley St

15- Filed OCT 6 - 1920, 191... ROBERT F KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 5, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10, 1920, to Oct 4 1920, that I saw h[e] alive on Oct 4 1920, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB.

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. 1 mos. ds.

(Signed) Albert L Levy M. D.

Oct 5 1920 (Address) 107 E. Mount

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Grove Run Chapel Balto Co Md.

DATE OF BURIAL. Oct 7 1920

20-UNDERTAKER Bertram B Gore

ADDRESS 1722 N Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D47077 HEALTH DEPARTMENT—CITY OF BALTIMORE D47077

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 17th St. Hospital WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carolyn Honan

(Residence in Baltimore: No. 514 S. Milton Ave St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) S.

6-DATE OF BIRTH, Sept. 22, 1916
(Month) (Day) (Year)

7-AGE, 4 yrs. mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none do
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, William Honan

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Caroline Meyer.

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Caroline Honan

(Address) 514 S. Milton Ave

15-

Filed OCT 6 - 1920 191 ROBERT B KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct. 4, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Lob
Influenza
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Colby (Coroner) M. D.

10-6-20 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cem. DATE OF BURIAL, Oct. 6, 1920

20-UNDERTAKER Lilly and Zeiler. ADDRESS 403 S. Wolfe St.

N. B. Entries must be made in ink. Any physician willfully making a false statement in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0947078

HEALTH DEPARTMENT—CITY OF BALTIMORE

0947078

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 427 N. Castle ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Musil Sr.

(a) RESIDENCE. No. 427 N. Castle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. — mos. — ds. How long in U. S., if of foreign birth? 51 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Frances Musil

6 DATE OF BIRTH (month, day, and year) Aug 7-56

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Himself

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Jos. Musil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Frances Musil
(Address) 427 N. Castle

15 Filed OCT 6 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1920

17 I HEREBY CERTIFY, That I attended deceased from May 10 1920 to Oct 3 1920

that I last saw him alive on Oct 2 1920

and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Chronic Nephritis
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dropsy

(Signed) W. Muncaster, M. D.

10-6 1920 (Address) 1001 W. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Oct 6 1920
20 UNDERTAKER Philip Hennig	ADDRESS Oct Athens

OCT 6 1920 Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D47079 HEALTH DEPARTMENT—CITY OF BALTIMORE D47079

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1315 Pressman St. 15 Ward) 120

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles D. Mitchell

(Residence in Baltimore: No. 1315 Pressman St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	married

6-DATE OF BIRTH, unknown (Month), (Day), 1882 (Year)

7-AGE,	If LESS than 1 day,
38 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Charles Grimmand

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Zora Mitchell

(Address) 1315 Pressman St.

15-

OCT 6 - 1920 ROBERT F. KRAUTER DEPUTY REGISTRAR

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 3, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) and Cirrhosis

(Duration) yrs. mos. ds.

(Signed) J. J. D. Hennessy M. D. (Coroner.)

Oct. 4, 1920 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bendick Whar's Woodlawn Cem. | DATE OF BURIAL, Oct. 6, 1920

20-UNDERTAKER JAMES H. DENNIS | ADDRESS 1303 PRESTMAN ST.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1947080

HEALTH DEPARTMENT—CITY OF BALTIMORE

1947080

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 N. Bronce St.: 16 WARD)

2-FULL NAME Isaac White.

(a) RESIDENCE. No. 715 N. Bronce ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. 1207

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maria Morris

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor & Sweeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Page White

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Julia Page (Address) 2444 Etting St.

15 Filed OCT 6 – 1920 ROBERT F. CLATTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1920, to Oct 4, 1920, that I last saw him alive on Oct 3, 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical - Physical

(Signed) Wm H Wright, M. D.

Oct 5, 1920 (Address) 1209 Prestman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 6 1920
20 UNDERTAKER JAMES H. DENNIS	ADDRESS 1303 PRESTMAN ST.

mation should be carefully supplied. Exact statement of OCCUPA-
be properly classified.
of certificates.
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of

Spec. 6-9-19—H. P. Co. 1000 Bks.

1047081 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047081

CERTIFICATE OF DEATH. 152

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 N. Gilmor ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Nelson

(a) RESIDENCE. No. 311 N. Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? N/a yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): ~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~

6 DATE OF BIRTH (month, day, and year) September 30, 1920

7 AGE — Years: ~ Months: ~ Days: ~ If LESS than 1 day 20 hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): ~

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. (State or country) Maryland.

PARENTS

10 NAME OF FATHER William Jones

11 BIRTHPLACE OF FATHER (city or town) Atlanta (State or country) Georgia

12 MAIDEN NAME OF MOTHER Jessie Nelson

13 BIRTHPLACE OF MOTHER (city or town) ~ (State or country) Howard County, Maryland

14 Informant (Address) Jessie Nelson Mother

15 Filed OCT 6 - 1920 19 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 1st 1920

17 I HEREBY CERTIFY, That I attended deceased from September 30, 1920, to October 1st, 1920, that I last saw her alive on October 1st, 1920, and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atilelasis

— (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) ~

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) J. Morris Reese, M. D.

10-2 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters — DATE OF BURIAL: Oct 6 1920

20 UNDERTAKER: JAMES H. DENNIS — ADDRESS: 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047082

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047082

CERTIFICATE OF DEATH.

91-119

REGISTERED NO.....

1-PLACE OF DEATH Baybrin Hospital

CITY OF BALTIMORE: (No. ..... ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jonette Hympel

(a) RESIDENCE. NO. 875 W. Fmstbd ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

be properly classified. Exact statement of OCCUPA-
of certificates.
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1865

7 AGE: Years 55 | Months — | Days — | If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do.

12 MAIDEN NAME OF MOTHER: Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant: Baybrin Hospital
(Address) Balto, Md.

15 Filed OCT 6 - 1920 ROBERT F. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1920, to Oct. 3, 1920,
that I last saw h e alive on Oct 3, 1920
and that death occurred, on the date stated above, at 9 15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Hemorrhagic Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical

(Signed) N. E. Edmunds M. D.

10/4/1920 (Address) Baybrin Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery.

DATE OF BURIAL: Oct. 6th 1920

20 UNDERTAKER: John Hoover & Son

ADDRESS: for Hollins St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47083 HEALTH DEPARTMENT—CITY OF BALTIMORE D47083

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 533 N. Decker Ave ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Montgomery

(a) RESIDENCE. No. 533 N. Decker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 3, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frank O Montgomery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Catherine Gott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pinta Pa

14 Informant Catherine Montgomery
(Address) 533 N Decker Ave

15 Filed OCT 6 - 1920 19 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 3 1920 to Oct 4 1920

that I last saw her alive on Oct 4 1920

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Twin Delivery. Premature birth. Almost 8 months

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Leovy M. D.

10/4. 1920 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Oct 6 1920
20 UNDERTAKER	ADDRESS
Geo. E. Cook.	Northern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D47084 HEALTH DEPARTMENT—CITY OF BALTIMORE D47084

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 Druid Hill Ave ST.; 18 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Lyle

(Residence in Baltimore: No. 1616 Druid Hill Ave St.; ..... yrs., ... mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
White	C	Infant

6-DATE OF BIRTH, Oct (Month) 5 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
.....yrs.....mos. 1 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thomas H Lyles

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Anna Douglas

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS ~~TRUE~~ TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos H Lyles

(Address) 1616 Druid Hill Ave

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 5 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 5 1920, to Oct 5 1920, that I saw ~~him~~ alive on Oct 5 1920, and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:

Premature birth
atelectasis

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY..... (Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Edw Stout M. D.

Oct 7, 1920. (Address) 812 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Ind Auburn Cem Oct 6., 1920

20-UNDERTAKER George H. Holland ADDRESS 1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

ROBERT B KRAUTER
OCT 6 - 1920
Burial Permit

Bryant

64708 5 HEALTH DEPARTMENT—CITY OF BALTIMORE 64708 5

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Wilson & Druid Hill Ave ST.: 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Corliss Bryant

(Residence in Baltimore: No. 1416 Mc Culloch St.; yrs. 26 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	married

6-DATE OF BIRTH, August 3, 1894
(Month) (Day) (Year)

7-AGE, 26 yrs. 2 mos. ds. If LESS than 1 day, hrs. or mln.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jacob Bryant

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Ina Brown

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grace Bryant

(Address) 1416 McCulloch St.

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 4, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. R. Hennessy M. D.
(Coroner.)

Oct 5, 1920 (Address) 1807 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Oct 7, 1920
20-UNDERTAKER	ADDRESS
George T. A. Gibson	513 Fallsway

ROBERT P. KRAUTER
OCT 6 1920
Burial Permit

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047086 HEALTH DEPARTMENT—CITY OF BALTIMORE 047086

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... St.: 25 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Green

(a) RESIDENCE. No. Fairfield, Md. (319 Ave. St., ... Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Oct 2 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Theo A. Arthur

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant (Address) Bay View Hosp. Balto, Md.

15 Filed OCT 6 - 1920 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1920, to Oct. 3, 1920.

that I last saw h e alive on Oct. 3, 1920

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Pleurisy Chronic Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? yes + autopsy

What test confirmed diagnosis? Clinical Findings.

(Signed) H. Fredonwith, M. D.

10/4/1920 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Oct 6 1920
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

√ 047087

047087

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5252 Reisterstown Rd (WARD) 27

2-FULL NAME Gertrude Lee Walters

(a) RESIDENCE. NO. 5252 Reisterstown St. Rd WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Walters

6 DATE OF BIRTH (month, day, and year) Aug 26/1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	2	6	

8 OCCUPATION OF DECEASED Housework

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cecilton Md

PARENTS

10 NAME OF FATHER James S Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cecilton Md

12 MAIDEN NAME OF MOTHER Sarah J Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cecilton Md

14 Informant Mary Walters (Address) 5252 Reisterstown Rd

15 Filed OCT 6 - 1920, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1920

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to Oct 5, 1920

that I last saw h alive on Oct 5, 1920

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not contracted

Did an operation precede death? Yes Date of 2 years ago

Was there an autopsy? no

What test confirmed diagnosis? Pathologist

(Signed) Wm A Cox, M. D.

, 19 (Address) Catonsville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Oct 7 1920
20 UNDERTAKER	ADDRESS
Martin Foster & Sons	1827 W Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47088

HEALTH DEPARTMENT—CITY OF BALTIMORE

Bowes CERTIFICATE OF DEATH.

1 19 D47088

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 E. 20th Street ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony W. Bowes

(a) RESIDENCE. No. 507 E. 20th Street ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Jan. 12-1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph T. Bowes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary C. Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Joseph T. Bowes (Address) 507 E. 20th Street

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4th 1920

17

I HEREBY CERTIFY, That I attended deceased from June 28 . 1920 . to Oct 4 . 1920 . that I last saw h m alive on Oct 4 . 1920 . and that death occurred, on the date stated above, at 9 A m

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) John Buhrach . M. D.

Oct 5 . 1920 (Address) 11 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	10/7/20 19
20 UNDERTAKER	ADDRESS
Chas. F. Evans & Son	Mt. Royal

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47089

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47089

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth T. Dunott

(a) RESIDENCE. NO. 1005 Calvert St. ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of widow of Thomas J. Dunott

6 DATE OF BIRTH (month, day, and year) June 14th 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Frederick
(State or country) Maryland

PARENTS

10 NAME OF FATHER Daniel Zacharias

11 BIRTHPLACE OF FATHER (city or town) Clear Spring
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth T. Zacharias

13 BIRTHPLACE OF MOTHER (city or town) Frederick
(State or country) Maryland

14 Informant Justus Dunott
(Address) 1732 Gladstone Ave. Roland Park

15 Filed ..., 19 ... Registrar

ROBERT B. ELLICOTT
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1920, to Oct. 5, 1920

that I last saw h[illegible] alive on Oct. 5, 1920

and that death occurred, on the date stated above, at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Carcinoma of bladder

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. C. Moreno, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick Md	Oct 7th 1920
20 UNDERTAKER Henry M. Jenkins Sons Co	ADDRESS Orchard Ave Catonsville

Spec.—8-24-14—M. & T.—2000 Bks.

D.47090

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47090

CERTIFICATE OF DEATH.

151

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 29-8½ St.- Fairfield ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Gross

(Residence in Baltimore: No. 29 8½ St.- St.; ....yrs., 3 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
M.	C.	Single

6-DATE OF BIRTH, June 13th 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. 23 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Ocey Pugh

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Annie Gross

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Gross

(Address) 29-8½ St Fairfield Md.

15-
OCT 6 - 1920
Filed....., 191.....
Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 6th, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 27 1920, to Oct. 6th 1920, that I saw him alive on Oct. 4th 1920, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Marasmus - Caused by general weakness at birth followed with improper feeding.

(Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) nothing to my knowledge

(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo. B. Dawson M. D.

Oct 6th 1920 (Address) 2-11 Church St. Curtis Bay.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Furnace Branch	Oct 6, 1920
20-UNDERTAKER	**ADDRESS**
J. L. Thomas' Son	168 W. Monroe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of the CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D.47091 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47091

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4709 Locust Ave ST.; 2 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Sommer

(Residence in Baltimore: No. Life St.; yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-SINGLE, ~~MARRIED~~, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, 10/5/1920 (Month) (Day) (Year)

7-AGE, one hour — yrs. mos. ds.

If LESS than 1 day, 1 hrs. or ~~1 min.~~

8-OCCUPATION:
(a) Trade, profession, or particular kind of work /
(b) General nature of industry, business, or establishment in which employed (or employer) ~~Self~~

9-BIRTHPLACE, (State or Country), 4709 Locust Ave

PARENTS.

10-NAME OF FATHER, John M. Sommer

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Kriezel

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John M. Sommer

(Address) 4709 Locust Ave

15-

Filed OCT 6-1920, 191

Robert P. Harrison, Registrar.
~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10/5/1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10/5/1920, for one hour, that I saw him alive on 10/5 1920, and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

Prematurity 6 mos

Life

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration) yrs. mos. ds.

(Signed) H. Wiesecke M. D.

10/5, 1920 (Address) 3900 Wash Blvd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Baltimore — DATE OF BURIAL, Oct 6, 1920

20-UNDERTAKER William Cook — ADDRESS, 502 E. North Ave

D.47092 HEALTH DEPARTMENT--CITY OF BALTIMORE D.47092

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 336 Maryland Ave. Westport St. 42 WARD 25)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Maria Louisa Lear

(Residence in Baltimore: No. 336 Maryland Ave Westport St.; 72 yrs. 6 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Nov. (Month) 20 (Day), 1849 (Year)

7 AGE: 70 yrs. 10 mos. 15 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Salem, N. J.

PARENTS

10 NAME OF FATHER: David Sparks

11 BIRTHPLACE OF FATHER (State or country): New Jersey

12 MAIDEN NAME OF MOTHER: Abagail Coffee

13 BIRTHPLACE OF MOTHER (State or country): New Jersey

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Victoria Lear

(Address) 336 Md Ave Westport

15 Filed OCT 6 - 1920 191 Robert P. Harrison, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. (Month) 5th (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26, 1920, to Oct 5th 1920 that I saw her alive on Oct 5th, 1920 and that death occurred, on the date stated above, at 6.55 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) ..... yrs. 6 mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Vernon H. London M. D.

Oct 5, 1920 (Address) 752 N. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Oct 7, 1920

20 UNDERTAKER: H Sanders & Son — ADDRESS: 1710 Eutaw

Spec.—6-9-19—H. P. Co—1000 Bks.

D. 47093 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 47093

150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 240 So. Madeira ST.: 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME STANISLAWA FILAR,

(a) RESIDENCE. NO. 240 So. Madeira ST., 1 st WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female,	White.	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 1/20.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland,

PARENTS

10 NAME OF FATHER Stanislaus Filar,

11 BIRTHPLACE OF FATHER (city or town) Poland,
(State or country)

12 MAIDEN NAME OF MOTHER Casmieria Klamut,

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland,

14 Informant Stanislaus Filar, (Father)
(Address) 240 So Madeira Street

15 Filed OCT 6 - 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1920, to Oct 6, 1920, that I last saw h[illegible] alive on Oct 6, 1920, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Congenital Valvular Stenosis
Dropsy

(duration) yrs. mos. 6 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William D. Ramut, M. D.

Oct. 6 19 20 (Address) 801 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	Oct 7" 1920
20 UNDERTAKER M. F. Sadowski	ADDRESS 906 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47094 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47094

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 501 N. Fremont St.: 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Schultz

(a) RESIDENCE. No. 501 N. Fremont St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married.

5a If married, widowed or divorced HUSBAND of (or) WIFE of Carrie Schultz

6 DATE OF BIRTH (month, day, and year) May 12 - 1867.

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	53	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocerman. 1

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Beck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Carrie Schultz
(Address) 501 N. Fremont St.

15 Filed ..., 19... Robert P. Harrison, Registrar
CT 6-1920 Burial Permit Clerk.

Zeller - 1818 E. Balto St.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 6 - 1920.

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1918, to Oct 6, 1920, that I last saw him alive on ..., 19..., and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.
10/6 1920 (Address) 1818 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 8- 1920
20 UNDERTAKER	ADDRESS
William Cook	502 E. Northam

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

143571 047095

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

55 047095

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 6 WARD)

2-FULL NAME Virginia Vaughn

(a) RESIDENCE. No. 1517 E. Fayette St. Baltimore St. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Wells.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Louise Vaughn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant [illegible]
(Address)

15 Filed OCT 7 - 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct. 2 1920, to Oct 5 1920,
that I last saw h[illegible] alive on Oct. 5 1920,
and that death occurred, on the date stated above, at 8 22 a. m.
The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) C W Darrison M. D.
, 19 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Oct 7 1920
20 UNDERTAKER	ADDRESS
Mrs Robt A Elliott	Ashland Va

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

2047096

HEALTH DEPARTMENT—CITY OF BALTIMORE

2047096

+64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sunday Sanitarium REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Athol - Frederick Road ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Fannie E. Hoozewerff

(Residence in Baltimore: No. Sunday Sanatarium St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Sept (Month) 16 (Day), 1840 (Year)

7-AGE, 80 yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Lady
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Justinfurn Hoozewerff

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Elizabeth Evans

13-BIRTHPLACE OF MOTHER (State or Country), Lancaster Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..Alfred J. Smullen M.D.

(Address)..Athol - Catonsville Md

15- OCT 7 - 1920 ROBERT B KRAUTER
Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 6 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 3 1920, to Oct 6 1920, that I saw h e alive on October 5 1920, and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Nephritis

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

½ hour (Duration) ....yrs....mos....ds.

(Signed) Alfred J. Smullen M. D.

Oct 6, 1920 (Address) Athol Catonsville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 3 mos. 3 ds. In the State 79 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? In Baltimore

Former or usual residence Ellicott City Md

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cem	10 — 8.., 1920
20-UNDERTAKER Henry M Jenkins Son Co	ADDRESS Orchard & McCulloh

CAUSE OF DEATH in plain terms, so that it may be properly classified. Information is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D47097 HEALTH DEPARTMENT—CITY OF BALTIMORE 104 D47097

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. Mercy & Christ's ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Seward

(Residence in Baltimore: No. Mercy & Christ's Hospital St.; yrs. 3 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, June (Month) 10 (Day), 1920 (Year)

7-AGE, yrs. 3 mos. 26 ds. — If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Virginia Seward

13-BIRTHPLACE OF MOTHER (State or Country), Taylor's Island

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss George Hutton

(Address) Franklin and Edmondson

15-

Filed....., 191.....

Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 6 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 7 1920, to Oct 6 1920, that I saw h[illegible] alive on Oct 6. 1920, and that death occurred, on the date stated above, at 12 A. m.

The CAUSE OF DEATH* was as follows:

Nutritional disturbance

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) S. J. Feilg[illegible] M. D.

Oct. 6, 1920 (Address) 702 E Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Oct. 8, 1920
20-UNDERTAKER Geo J Smith	ADDRESS 1000 Fayette st

Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D47098 D47098

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 N. Exeter ST.: 5 WARD)

2-FULL NAME Calvin Price

(a) RESIDENCE. NO. 5 N. Exeter ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. 3 mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Boy	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 17, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Calvin Price

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Natalie Tulack

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Miss. Eliz. Taylor
(Address) 1818 Bloom St.

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-6 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 5 1920, to Oct-6 1920, that I last saw him alive on Oct-6 1920, and that death occurred, on the date stated above, at 7 30 P.m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Mal nutrition

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Boston Hotel

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? The Mother Superior

(Signed) Clarence R McClintock M. D.

. 19 (Address) 1818 Bloom St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 8 192
20 UNDERTAKER George J. Smith	ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1437241 1047099 — 1047099

CERTIFICATE OF DEATH.

X 104

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hosp., ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Regan

(a) RESIDENCE. No. 645 Dover St ST., WARD. N. C.
(Usual place of abode)

Length of residence in city or town where death occurred Eubaugen yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March-2-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina
(State or country)

PARENTS

10 NAME OF FATHER Robt. Ragan

11 BIRTHPLACE OF FATHER (city or town) North Carolina
(State or country)

12 MAIDEN NAME OF MOTHER Fannie Stevens

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Husband Record
(Address) 645 N. H. St.

15 Filed OCT 7-1920, 19 ROBERT [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5-th 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 14th 1920, to Oct 5-th, 1920, that I last saw h.. alive on Oct 5-th, 1920, and that death occurred, on the date stated above, at 5 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Enteritis (not dysentery)

(duration) — yrs. — mos. 27 ds.

CONTRIBUTORY (Secondary)

(doration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] Dawson, M. D.

, 19 (Address) J.H.H. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity	Oct 7 1920
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1737 Eager

CAUSE OF DEATH must be properly certified, and the Certificate filed with the Registrar of the district in which death occurred, before a Burial Permit will be issued. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47100 HEALTH DEPARTMENT—CITY OF BALTIMORE D47100

CERTIFICATE OF DEATH. 19V

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 N. Fremont ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jane Keating

(a) RESIDENCE. No. 618 N. Fremont ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 26 - 1835

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
85	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER David Hammond

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Griffin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs. Grace Haupt
(Address) Gardenville Md

15 Filed OCT 7 - 1920 ROBERT E. CRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 3 , 1920, to Oct 5 , 1920

that I last saw h ~~e~~live on Oct 4 , 1920

and that death occurred, on the date stated above, at 1.03 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Organic Heart disease. (Myocarditis)

(duration) 14 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jane Brown, M. D.

Oct 5. 1920 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct. 8 1920
20 UNDERTAKER George J. Smith	ADDRESS 1000 N. Fremont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1047101 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047101

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital St.: 13 WARD) 75-001
REGISTERED No. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo Williams
(Residence in Baltimore: No. 199 Falls Road (Race) St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male
4-COLOR OR RACE, Colored
5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married
6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1863 (Year)
7-AGE, 57 yrs. ..... mos. ..... ds.
If LESS than 1 day, ...hrs. or.....min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Janitor
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country). Porto Ind
PARENTS.
10-NAME OF FATHER, Chas H Williams
11-BIRTHPLACE OF FATHER (State or Country), Ind
12-MAIDEN NAME OF MOTHER Priscilla Lough
13-BIRTHPLACE OF MOTHER (State or Country), Ind
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE,
(Informant) Matilda A. Keegan
(Address) 172 Virginia Ave

15- OCT 7 - 1920 ROBERT B KRAUTER
Filed....., 191.... Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) / 4 (Day), 1920 (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.
The CAUSE OF DEATH* was as follows:
Fracture of Skull
Auto-accident
(Duration) ..... yrs. ..... mos. 1 hr. ds.
CONTRIBUTORY (Secondary) Concussion
(Duration) ..... yrs. ..... mos. 1hr. ds.
(Signed) Wm H Wade M. D.
(Coroner)
10/5/20, 191... (Address) 143 E Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mare Hill Cem DATE OF BURIAL, Oct 7, 1920
20-UNDERTAKER Raymond Studley ADDRESS 578 Park Ave

N. B.—Every item of information should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

647/02 HEALTH DEPARTMENT—CITY OF BALTIMORE 647/02

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Easternn Ave St.: 726 (WARD) REGISTERED No. C 175

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Hess

(Residence in Baltimore: No. Dowell & 23rd St.: yrs 65 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July 19, 1846
(Month) (Day) (Year)

7-AGE, 74 yrs. 2 mos. 14 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Sebastian Hess

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Wahl

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mina Wachsmuth
(Address) O'Donnell & 23d St.

15- OCT 7 - 1920 ROBERT B BRAUER
Filed....., 191.... BURIAL PERMIT CLERK Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 3, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Killed by being struck by train

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Signed Henry Ryan M. D.
(Coroner)
10/7/20 191... (Address) 8004 Edna Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oakland Cem | DATE OF BURIAL, Oct 7, 1920

20-UNDERTAKER Zickler & Zickler | ADDRESS 1739 E. Eager

N. B.—Every item of information called for should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

847103

CERTIFICATE OF DEATH.

19 D 47103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 S. Charles St. ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Ruby Marshall

(Residence in Baltimore: No. 113 S. Charles St.; 7 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, Oct. 1, 1914
(Month) (Day) (Year)

7-AGE, 6 yrs. 0 mos. 7 da. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Charles Co. Md.

PARENTS.

10-NAME OF FATHER. Charlie Marshall

11-BIRTHPLACE OF FATHER (State or Country). Charles Co. Md.

12-MAIDEN NAME OF MOTHER Georgia Cobble

13-BIRTHPLACE OF MOTHER (State or Country). Charles Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Marshall Father

(Address) 113 S. Charles St.

15-

Filed OCT 7-1920, 191.

ROBERT B. KRAUTER
BURIAL PERMIT CLERK
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 7; 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 15th 1920, to Oct. 7 1920, that I saw h... alive on Oct. 6th 1920, and that death occurred, on the date stated above, at 2.01 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonal Tuberculosis

(Duration) yrs. 1 mos. 16 da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 18 da.

(Signed) [illegible] M. D.

Oct. 7; 1920 (Address) 2111 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cem.	Oct. 8, 1920.
20-UNDERTAKER	**ADDRESS**
C. T. Brown & Son	Dorsey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item important. See instructions on back of certificate.

D47104

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47104

CERTIFICATE OF DEATH.

8 / 164 D47104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2402 E. Oliver ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora B. Connelly

(a) RESIDENCE. No. 2402 E. Oliver ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Wm. B. Connelly

6 DATE OF BIRTH (month, day, and year) June 2nd 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	4	2	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work: House-work

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Wm. F. Fields

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Georgiana Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Wm. B. Connelly

(Address) 2402 E. Oliver St

15 Filed ... 19 ... Registrar

ROBERT P. LAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5th 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 24 1920, to Oct 5 1920, that I last saw h[er] alive on Oct 5 1920, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ?

(Signed) N. B. Harmon, M. D.

, 19 20 (Address) 1301 N Rat Rt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Oct. 8th 1920
20 UNDERTAKER: Philip Herwig	ADDRESS 2016 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

* over

Spec.—8-24-14—M. & T.—2000 Bks.

D47105

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1408 Madison Ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nettie M Depew.

(Residence in Baltimore: No. 1408 Madison Ave St.; ....yrs., 3 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White.	Married

6-DATE OF BIRTH, Sept 6, 1886
(Month) (Day) (Year)

7-AGE 34 yrs. 1 mos. 0 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 37

9-BIRTHPLACE, (State or Country). Clifton W. Va.

PARENTS.

10-NAME OF FATHER, E. K. Holland.

11-BIRTHPLACE OF FATHER (State or Country), W. Va.

12-MAIDEN NAME OF MOTHER Maud Roberts

13-BIRTHPLACE OF MOTHER (State or Country), Mason City W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. A. Depew

(Address) 1408 Madison Ave.

15-

ROBERT B. RESLER
Burial Permit Clerk

Filed....., 191.....
Registrar.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 6, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 11 1920, to Oct 6 1920, that I saw h-er alive on Oct 6 1920, and that death occurred, on the date stated above, at 9 30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma cervix uteri.

(Duration) 2 yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Dudley C Roberts M. D.

Oct. 6, 1920 (Address) 1418 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Glenville W Va.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Sewell W. Va	Sept 7, 1920

20-UNDERTAKER	ADDRESS
Chas Turner Inc	444 Gay

D47106 HEALTH DEPARTMENT—CITY OF BALTIMORE D47106

CERTIFICATE OF DEATH. 186

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Edgewood Court 14th St. St.; 15 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Hill

(Residence in Baltimore: No. 1414 N. Bruce St. St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	widowed

6-DATE OF BIRTH, April (Month) 4 (Day), 1874 (Year)

7-AGE, 46 yrs. 5 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Driver U.V.
(b) General nature of industry, business, or establishment in which employed (or employer): (Team)

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosella Hurley

(Address) 1414 N. Bruce St

15- OCT 7 - 1920

Filed ....., 191.... ROBERT E. LEACH. Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 2 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage from ruptured lungs due to multiple fractures of left side (Accident) (Duration) ..... yrs. ..... mos. 5 min. ds.

CONTRIBUTORY (Secondary) Probably struck by flying must be present if primary is not) (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Oct. 5, 1920 (Address) 2802 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Oct 7, 1920

20-UNDERTAKER, Edw. Ringgold — ADDRESS 1463 N. Carey St

N. B.—Every item of information should be given as accurately as possible, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Makarewicz

647107

HEALTH DEPARTMENT—CITY OF BALTIMORE

647107

40

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2006 Fountain ST.: W WARD)

2-FULL NAME Josephine Makarewicz

(a) RESIDENCE. NO. 2006 Fountain ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Makarewicz

6 DATE OF BIRTH (month, day, and year) March 19 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Feliks Pietrawski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Weronik ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Czeslawa Tyler
(Address) 2006 Fountain

15 Filed OCT 7 - 1920 ROBERT F. KLAUBER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/5 1920

17 I HEREBY CERTIFY, That I attended deceased from August 10, 1920, to Oct 5, 1920, that I last saw her alive on Oct 5, 1920, and that death occurred, on the date stated above, at 10.50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) yrs. 4? mos. ds.

CONTRIBUTORY (Secondary) Anthemia & Heart failure

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Signs & symptoms

(Signed) Thos A Pietrzyk, M. D.

, 19 (Address) 1623 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 8 1920

20 UNDERTAKER ADDRESS

John M Weber 1803 Bank

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D47108 ✓ 151 D47108

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 N. Eastern St.; 6 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Kotsiovec

(Residence in Baltimore: No. 523 N Eastern St.; ..... yrs., ... mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Infant

6-DATE OF BIRTH, Oct 3, 1920 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
.....yrs. .....mos. 3 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Louis Kotsiovec

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Mary Klima

13-BIRTHPLACE OF MOTHER (State or Country), Balt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Kotsiovec

(Address) 523 N. Eastern St

15-

Filed ..... 191.....

OCT 7 - 1920

ROBERT B. KRAUTER

Registrar.

CAUSE OF DEATH must be plainly stated, and all questions answered as far as possible. Every item is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 6, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 3 1920, to Oct 6 1920, that I saw him alive on Oct 6 1920 and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Malformation of Rectum
Premature birth Second
Cousin family (Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

10 6, 1920 (Address) 608 N. Dithridge St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Oct 8, 1920

20-UNDERTAKER	ADDRESS
Fidel Brockstein	1906 Eastern Ave

Spec.—8-24-14—M. & T.—2000 Bks.

047109 HEALTH DEPARTMENT—CITY OF BALTIMORE 047109

CERTIFICATE OF DEATH.

REGISTERED NO. C 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 W. Balto ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Catherine Blankenship

(Residence in Baltimore: No. 705 W. Baltimore St.; 1 yrs., 1 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Aug (Month) 1 (Day), 1919 (Year)

7-AGE,	If LESS than 1 day,
1 yrs. 2 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William Blankenship

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Catherine Letts

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Blankenship

(Address) 705 W. Baltimore St

15- OCT 7 - 1920 ROBERT E KRAUTER

Filed....., 191.. Burial Permit Clerk.

Registrar.

CAUSE OF DEATH to fill in plain terms, so that it may be properly important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 5 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 5 1920, to Oct. 5, 1920, that I saw her alive on Oct 6, 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria (Nasal and Pharyngeal)

(Duration)....yrs....mos. 4 ....ds.

CONTRIBUTORY (Secondary).....

(Duration)....yrs....mos....ds.

(Signed) Eugene L Penwell M. D.

Oct. 6, 1920 (Address) 2914 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
St. Peters Cemetery	Oct. 7, 1920
20-UNDERTAKER	ADDRESS
M. J. Flynn	1422 Light st

Spec.—8-24-;:—M. & T.—2000 Blks.

D.47110 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47110

54

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 Scott St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Holtz

(Residence in Baltimore: No. 202 Scott St. St. 46 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Aug 1, 1874 (Month) (Day) (Year)

7-AGE, 46 yrs. 7 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Salesman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Holtz

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie G. Holtz

(Address) 202 Scott St.

15-

Filed OCT 7 1920, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 6, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1920, to Oct 6th 1920, that I saw him alive on Oct 5th 1920, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) H. H. Lucke M. D.

Oct 6..., 1920. (Address) 6.6 N. Carrollton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem — DATE OF BURIAL, ..., 191...

20-UNDERTAKER Robert Brooks — ADDRESS 178 Calhoun

CAUSE OF DEATH must be stated plainly and fully. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D. 47111

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 47111

CERTIFICATE OF DEATH.

105

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S. 14th St.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dolores A Loewer

(Residence in Baltimore: No. 319 S. 14th St. St.; 5 yrs.. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept 2, 1915
(Month) (Day) (Year)

7-AGE, 5 yrs. 1 mos. ..... da.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, George Loewer

11-BIRTHPLACE OF FATHER (State or Country), Balto md

12-MAIDEN NAME OF MOTHER Anna Lohse

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Loewer

(Address) 319 S 14th St

15-

Filed OCT 7 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CAUSE OF DEATH. See instructions on back of certificate. important.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 6, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6 1920, to Oct 6 1920, that I saw h[illegible] alive on Oct 6 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dysentery
(Ileo Colitis)
(Duration) ..... yrs. ..... mos. 10 ..... da.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation
(Duration) ..... yrs. ..... mos. 2 ..... da.

(Signed) Leo Kaltenecker M. D.

Oct 7 1920 (Address) 32 E Dorsett Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Farmer or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Oct 9, 1920

20-UNDERTAKER J. J. Herr

ADDRESS 156 N. Luzerne Ave.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47112 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47112

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~Rear~~ 820 S. Grove st / ST.; / WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosie Chevaux

(Residence in Baltimore: No. 820 S Grove St St.; 28 yrs., 2 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 31 (Day), 189 (Year)

7-AGE, 28 yrs. 2 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Michal Stefanski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Magdalena Bielinska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Magdalena Bielinska

(Address) 820 S. Grove St.

15-

Filed OCT 7 1920, 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 5th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 22 1920, to Oct. 5th 1920, that I saw her alive on Sept. 30 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cut. Intercutosis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) C.S. Shaw M. D.

10/6/20, 191.. (Address) 408 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St Stanislaus Cem

DATE OF BURIAL. Oct 8, 1920

20-UNDERTAKER Stanley Fialkowski

ADDRESS 1005 Glenwood Ave

CAUSE OF DEATH must be stated plainly and accurately. Use no abbreviations or terms not understood generally. Do not report symptoms or modes of dying, but the diseases or conditions which caused death. Indefinite terms, such as "Debility," "Old Age," "Paralysis," "Convulsions," "Heart Failure," "Cancer," "Tumor," "Abscess," "Child-bed," "Fever," "Inflammation," "Hemorrhage," "Accident," "Suicide," "Homicide," "Found Dead," "Unknown," are not sufficient. Deaths from violence must state the means of injury, and whether accidental, suicidal, or homicidal. Deaths from any of the diseases peculiar to females must state whether single, married, widowed, or divorced. Deaths of infants must state whether legitimate or illegitimate. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1060 Bks.

D.47113 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47113

CERTIFICATE OF DEATH.

98

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Patience

(a) RESIDENCE. No. 808 Pratt st. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: James Patience

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scottland

12 MAIDEN NAME OF MOTHER: Annie Franschal

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Hospital Records (Address) M.T.H.

15 Filed OCT 7 - 1920 16 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1920, to Oct. 5, 1920, that I last saw h im alive on Oct. 5, 1920, and that death occurred, on the date stated above, at 11.50 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. J. Cogley, M. D.

10-5-20. 19 (Address) Municipal Tuberculosis Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: OCT 7 - 1920 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Part should not be left blank. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 47114

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 47114

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Schomburg

(a) RESIDENCE. No. 925 W. Baltimore ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29/887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Scrubber 078

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railways Co Balto. Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER James Preston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Sears

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Clarence E Blum

(Address) 925 W. Baltimore St

15 Filed OCT 7- 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 1920

17 I HEREBY CERTIFY, That I attended deceased from 9/29 . 1920 . to 10/6 . 1920 . that I last saw h alive on 10/6 . 1920 . and that death occurred, on the date stated above, at 6.50 a (p) m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Irwin D. Ridgely, M. D.

10/6 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 8 1920
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 W. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

20.47115 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.47115

CERTIFICATE OF DEATH.

64

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 411 E. Cross St. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura V. Harvey

(Residence in Baltimore: No. 411 E. Cross St.

64 7 9
St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Widow.

6-DATE OF BIRTH, February 26th. 1856, 1856.
(Month) (Day) (Year)

7-AGE, 64 yrs. 7 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, William H. Ward.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Emily Roberts.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Milton J. Harvey. (son)

(Address) 411 E. Cross St.

15- Robert P. Harrison,

Filed OCT 9 1920, 191.....

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 5th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Oct 6th 20, 191... (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	Oct 8, 1920

20-UNDERTAKER William Cook ADDRESS 503 E. North Ave

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47116 ✓ D.47116

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Gralley

(a) RESIDENCE. No. 612 Bartlett ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. Unknown mos. ds. How long in U. S., if of foreign birth Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73			

8 OCCUPATION OF DECEASED 104

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Casper Gralley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address) M. T. H.

15 Filed OCT 7 1920 19 Robert P. Lattimore, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6, 19 20

17 I HEREBY CERTIFY, That I attended deceased from March 22 19 19, to Oct. 6, 19 20, that I last saw him alive on Oct. 6, 19 20, and that death occurred, on the date stated above, at 7.40 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. Gralley, M. D.

10-7-20, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL Oct 9 1920

20 UNDERTAKER William Cook

ADDRESS 502 E. Hoff

CAUSE OF DEATH in plain terms, so that it may be properly classified. INFORMATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47117

CERTIFICATE OF DEATH.

64 D47117

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 E. Lombard ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Bleach

(a) RESIDENCE. NO. 1309 E Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Bleach

6 DATE OF BIRTH (month, day, and year) Jan 15 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Alex Cunningham
(Address) 307 E. Lombard St

15 Filed OCT 8- 1920 19 ROBERT S KRAUSER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1920, to Oct 6, 1920, that I last saw h[illegible] alive on Oct 5, 1920, and that death occurred, on the date stated above, at 10 40 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 9 mos. 28 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. W. Needwood M. D.

Oct 6, 1920 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Oct 9 1920
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47118

CERTIFICATE OF DEATH.

91 D47118

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 64 Pierce ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Lindsay

(Residence in Baltimore: No. 64 Pierce Street St.; yrs. 8 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: June (Month) 21 (Day), 1912 (Year)

7-AGE: 0 yrs. 3 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Charles Lindsay

11-BIRTHPLACE OF FATHER (State or Country): Chesterfield Va

12-MAIDEN NAME OF MOTHER: Louise Colton

13-BIRTHPLACE OF MOTHER (State or Country): Chesterfield Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Lindsay

(Address) 641 Pierce Street

15- Pierce

Filed OCT 8 - 1920, 191.... ROBERT B KRAUTER Registrar.

Burial Permit Issued

CAUSE OF DEATH must be filled in plainly and completely. Every question must be answered or the certificate will be returned. Underlining or quotation marks are not necessary. Do not abbreviate. Write out the full name of the cause of death. Indefinite and unsatisfactory causes of death will not be accepted. Consult the list of diseases in the Physician's Pocket Reference Book. Cause of death must be certified to by a physician, if there was one in attendance during the last illness of the deceased. If there was no physician in attendance, the undertaker must report the case to the Coroner. Causes of death which may be the result of violence must be reported to the Coroner. Deaths from contagious diseases must be reported at once by telephone. Births and deaths must be reported within 24 hours. Penalty for failure to report births or deaths, $5.00 to $20.00. (See Section 137 of Ordinance.) Information required by this certificate is important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Oct (Month) 6 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 6 1920, to Oct 6 1920, that I saw him alive on Oct 6 1920, and that death occurred, on the date stated above, at 2 pm.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. L. Easton M. D.

Oct 7, 1920 (Address) 324 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Oct 8, 1920

20-UNDERTAKER: Daniel Easton

ADDRESS 916 Lemmon ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47119 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D47119

50

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1014 N. Central Ave ST.: 10 WARD)

2-FULL NAME Catherine Potts

(a) RESIDENCE. No. 1014 N. Central Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late Mr. Potts.

6 DATE OF BIRTH (month, day, and year) July 28 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Stephen Kirchenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Stamper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Anna Potts.
(Address) 1014 N. Central Ave

15 Filed OCT 8— 1920 ROBERT F. KRAUTER Registrar

Burial Permit Oct 8

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1920

17

I HEREBY CERTIFY, That I attended deceased from 2-25-20, 1920, to 10-6-20, 1920, that I last saw h. alive on Oct 5-20, 1920 and that death occurred, on the date stated above, at 7 A.M. a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Regurgitation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) C. Mitchell, M. D.

(Address) 1001 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct 9 1920
20 UNDERTAKER	ADDRESS
Henry Hoerle Son	1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

042120 HEALTH DEPARTMENT—CITY OF BALTIMORE 042120

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Byrd

(a) RESIDENCE. No. 1821 White st. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Albert Byrd

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Anna Jones

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed OCT 8 - 1920 19 ROBERT B. BRADEN Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6, 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1920, to Oct. 6, 1920, that I last saw her alive on Oct. 5, 1920, and that death occurred, on the date stated above, at 9.05 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? .....

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. Digney, M. D.

10-6-20. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	10-8 1920
20 UNDERTAKER Jno. H. Toadvin	ADDRESS 142 W. Hill St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Fatal statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D47121

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47121

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Margaret L. Clark ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. 1134 W. Lombard

(a) RESIDENCE. No. 1134 W Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar - 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Jas. E. Clark

(Address) 1133 W Lombard St

15 Filed OCT 8 - 1920 ROBERT E [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1920, to Oct 6, 1920, that I last saw h... alive on Oct 5, 1920, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Norwood, M. D.

Oct 6, 1920 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Oct 6 1920
20 UNDERTAKER	ADDRESS
John J. Fields	1200 W Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

647122 647122 104

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1525 Baltimore ave ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Kelly

(a) RESIDENCE. No. 1525 Baltimore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Aug 10-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John J Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Peyton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John J Kelly
(Address) 1525 Baltimore ave

15 Filed OCT 8 — 1920 ROBERT B BRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1920, to Oct 7, 1920, that I last saw h[illegible] alive on Oct 7, 1920, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Toxic Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) J Wardell M. D.

Oct 10. 1920 (Address) 1 E 39 Williams

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Oct 8 19

20 UNDERTAKER Margaret B Flynn ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47123 HEALTH DEPARTMENT—CITY OF BALTIMORE D47123

CERTIFICATE OF DEATH. 104 v

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1338 Whatcoat ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Beatrice Toy

(a) RESIDENCE. No. 1338 Whatcoat ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 29/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Jerome Toy

11 BIRTHPLACE OF FATHER (city or town) Charles Co (State or country) Md.

12 MAIDEN NAME OF MOTHER Pearl Hall

13 BIRTHPLACE OF MOTHER (city or town) Charles Co (State or country) Md.

14 Informant Pearl Toy (Address) 1338 Whatcoat St.

15 Filed OCT 8 – 1920, 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1920, to Oct 7, 1920, that I last saw her alive on Oct 6, 1920, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E William Frey M. D.

9/7, 1920 Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 8 1920
20 UNDERTAKER JAMES H. DENNIS	ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT NATURE OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D47124

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47124

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 N. Vincent ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Spencer

(a) RESIDENCE. No. 1602 N. Vincent ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49 yrs.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Cement Laborer

(c) Name of employer Chas. Gridley

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant William Lomax (Address) 1602 N. Vincent St.

15 Filed OCT 8 - 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 7, 1920

17 I HEREBY CERTIFY, That I attended deceased from September 30, 1920, to October 6, 1920, that I last saw him alive on October 6, 1920, and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) John D. Quinn, M. D.

10/8 1920 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 9 1920

20 UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2047125 HEALTH DEPARTMENT—CITY OF BALTIMORE 2047125

CERTIFICATE OF DEATH.

175-004

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME E. Norman Carpenter

(Residence in Baltimore: No. 310 N. Calhoun st- St.; (yrs., 44 mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 1 (Day), 1858 (Year)

7-AGE, 62 yrs. 4 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tobacco Inspector
(b) General nature of industry, business, or establishment in which employed (or employer)..... B&O R.R.

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John E. Carpenter

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah C. Posey

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Virginia T. Carpenter

(Address) 310 N. Calhoun St

15-

Filed....., 191.... Registrar.

ROBERT B. KRAUTER
OCT 8 1920
BUREAU OF VITAL STATISTICS

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 6 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, ~~autopsy or inquiry~~.) thereon and from the evidence obtained by said..... (Inquest, ~~autopsy or inquiry~~.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull, accidentally Struck by car United R.R. Co's, a few hours

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) Accident

(Duration)..... yrs..... mos..... ds.

(Signed) H. H. Forrest M. D. (Coroner.)

10-7..., 1920 (Address) 11 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem

DATE OF BURIAL, Oct. 9..., 1920

20-UNDERTAKER Chas. E. Franck

ADDRESS 802 Madison Av

D47126 HEALTH DEPARTMENT—CITY OF BALTIMORE D47126

CERTIFICATE OF DEATH. X 182

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. Md. General Hosp. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Hubbard

(Residence in Baltimore: No. non resident) (Sparrows Point, Md. St. ~~yrs.~~ 3 mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: January (Month) 19 (Day), 1897 (Year)

7-AGE: 23 yrs. 9 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer (general) D40
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): South Carolina

PARENTS.

10-NAME OF FATHER: Jas. Hubbard

11-BIRTHPLACE OF FATHER (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: Hattie Pairy

13-BIRTHPLACE OF MOTHER (State or Country): N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. Hubbard

(Address) 1319 Ross St, Richmond Va.

15-

Filed....., 191.... Registrar.

OCT 8 1920 ROBERT B. KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 6, (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Revolver wounds of abdomen (Homicidal)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Oct. 18, 1920 (Address) 2807 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death Md. Gen. Hosp. ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Sparrows Point Md.

Former or usual residence Sparrows Point Md.

19-PLACE OF BURIAL, OR REMOVAL: Richmond Va. DATE OF BURIAL, Oct. 8 1920

20-UNDERTAKER: Samuel Tinsley ADDRESS 518 N Biddle St

Spec.—8-24-14—M. & T.—2000 Bks.

D47127 HEALTH DEPARTMENT—CITY OF BALTIMORE D47127

CERTIFICATE OF DEATH.

282

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 540 N. Calvert ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Murphy Days

(Residence in Baltimore: No. 540 N Calvert St.; 16 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) Unknown (Day) ....., 1851 (Year)

7-AGE, 39 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cooter
(b) General nature of industry, business, or establishment in which employed (or employer) 9th

9-BIRTHPLACE, (State or Country) South Carolina

PARENTS.

10-NAME OF FATHER, Isaac Days

11-BIRTHPLACE OF FATHER (State or Country), S. C.

12-MAIDEN NAME OF MOTHER Martha Tiley

13-BIRTHPLACE OF MOTHER (State or Country), S.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nancy Reese

(Address) 110 N Eutaw St

15-

Filed OCT. 8-1920, 191..... SORREY E. SAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 6th (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 21st 1920, to Oct 5th 1920, that I saw h.. last alive on Oct 5th 1920, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

..... (Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) House Known

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas J Keller M. D.

Oct 6th, 1920 (Address) 1 mar monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Loudenslager Oct 8, 1920

20-UNDERTAKER Samuel A. Hendley ADDRESS 78 N Eutaw

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047128

HEALTH DEPARTMENT—CITY OF BALTIMORE

× 45

047128

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Johns Hopkins Hospital St., 21 7 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Conley

(a) RESIDENCE. No. Clinchco Virginia St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Conley

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Miner 086

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER John Conley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Mary Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant Hospital Record (Address) J. H. H.

15 Filed OCT 8 1920 19 ROBERT E [illegible] Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7-20 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1920, to Oct 7, 1920, that I last saw him alive on Oct 7, 1920, and that death occurred, on the date stated above, at 7 30 P.M.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Retro-vesical Sarcoma

(duration) 0 yrs. 10 mos. 0 ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) W. H. Bailey, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Colburn Va	Oct 8 1920
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette

CAUSE OF DEATH must be plainly written, so that it may be understood by persons in all parts of the country. See instructions on back of certificates. TION is very important.

Spec.—B 24 14—M. & T.—2000 Blks.

D47129 HEALTH DEPARTMENT—CITY OF BALTIMORE N47129

CERTIFICATE OF DEATH.

150

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 N. Payson ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Lee Thompson

(Residence in Baltimore: No. 1705 N. Payson St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Oct (Month) 6 (Day), 1920 (Year)

7-AGE, ✓ yrs. ✓ mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Clyde Vernon Thompson

11-BIRTHPLACE OF FATHER (State or Country), Kentucky

12-MAIDEN NAME OF MOTHER May Cecilia Keating

13-BIRTHPLACE OF MOTHER (State or Country), New York.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo C Shannon

(Address) 700 Fulton ave

15-

Filed OCT 8 - 1920 191 ROBERT B KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 7 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 6 1920, to Oct 7 1920, that I saw h ~~em~~alive on Oct 7 1920, and that death occurred, on the date stated above, at 11p m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation of heart

(Duration) ✓ yrs. ✓ mos. 1 ds.

CONTRIBUTORY (Secondary) Prolonged labor

(Duration) ✓ yrs. ✓ mos. — ds.

(Signed) George C Shannon M. D.

Oct 7, 1920 (Address) 700 Fulton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters — DATE OF BURIAL, Oct 8, 1920

20-UNDERTAKER Harlan Fahey Sons — ADDRESS 1827 W North Ave

important. See instructions on back of certificate.

Wermuth.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47130 HEALTH DEPARTMENT—CITY OF BALTIMORE D47130

CERTIFICATE OF DEATH. 40

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 S. Wallington ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina Wermuth.

(a) RESIDENCE. No. 421 S. Wallington ST., 2 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Wermuth.

6 DATE OF BIRTH (month, day, and year) Aug 20th 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Wilhelm Raehmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Margt. Bergmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Wermuth (Address) 421 S. Wallington St.

15 Filed OCT 8 - 1920 ROBERT E KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5th 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug-10 1920 to Oct 5 1920.

that I last saw h alive on Oct 5 1920.

and that death occurred, on the date stated above, at 8.45 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) General Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Dr. R. A. Brunner, M. D.

(Address) 125 W. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Oct 8 1920
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wallington St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Brief statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

947131 HEALTH DEPARTMENT—CITY OF BALTIMORE 947131

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 N. Gilmor St.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jos. Schmitt.

(a) RESIDENCE. NO. 825 N. Gilmor ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White.	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Dora Schmitt

6 DATE OF BIRTH (month, day, and year) Mch 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Schmitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant (Address) Mrs. Marcia Schmitt. 825 N. Gilmor.

15 Filed ..... 19.. ROBERT B [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1920. to Oct 9, 1920. that I last saw h[illegible] alive on Oct 9, 1920. and that death occurred, on the date stated above, at 1.20 A.M.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ed Keller, M. D.

Oct 9 1920 (Address) 1937 Gorsuch Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Oct 9 1920
20 UNDERTAKER Lilly and Zeile	ADDRESS 1038 Mad Ave

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Date Name and Address of Undertaker must be given on back of certificates.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47132 HEALTH DEPARTMENT—CITY OF BALTIMORE D47132

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 E. Biddle ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Thim

(a) RESIDENCE. NO. 1031 E. Biddle St ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James J. Thim.

6 DATE OF BIRTH (month, day, and year): Aug 27-1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework (37)

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Co. Md.

PARENTS

10 NAME OF FATHER: Theodore Gill.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Md.

12 MAIDEN NAME OF MOTHER: Laura Cornthwaite

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md.

14 Informant (Address): James J. Thim 1031 E. Biddle St.

15 Filed OCT 8 1920 ROBERT F. LEATHER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1920, to Oct. 6, 1920, that I last saw her alive on Oct. 6, 1920, and that death occurred, on the date stated above, at 8.50 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis (5)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of none

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) J. Lee Magruder, M. D.

(Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Oct 9 1920
20 UNDERTAKER	ADDRESS
Lilly & Zile	403 S. Broadway

CAUSE OF DEATH to be plainly written, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047133 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047133

114

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH St. Joseph's Hospital ST.: 20 WARD)

CITY OF BALTIMORE) (No.

2-FULL NAME Mary Wicke.

(a) RESIDENCE. NO. 815 S. Smith St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	M. Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22 - 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER James Clark

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Anna Falkenstein
(Address) 3808 Fernwood Ave

15 Filed OCT 8 - 1920 ROBERT F. FRAZIER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1920, to October 6, 1920.
that I last saw h[illegible] alive on Oct 6, 1920
and that death occurred, on the date stated above, at 11.15 P. m.
The CAUSE OF DEATH* was as follows: Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cholecystitis & Cholelithiasis (duration) about 4 years ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Sept 27, 1920
Was there an autopsy? No.
What test confirmed diagnosis? Laschenrich M. D.
(Signed)
, 19 (Address) St Joseph's Hosp. Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Oct. 11 1920
20 UNDERTAKER Lilly and Zeile	ADDRESS 403 S. Broadway

CAUSE OF DEATH must be given in plain terms, so that a non-medical person can understand it. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D47134

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47134

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 Beaumont Ave ST.; 27 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick Donnelly

(Residence in Baltimore: No. 702 Beaumont Ave — Same Ward St.; 1 yrs., 2 mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Widower

6-DATE OF BIRTH, February 12, 1851.
(Month) (Day) (Year)

7-AGE, 69 yrs. 4 mos. 5 ds.

If ~~LESS~~ than 1 day, ... hrs. or ~~.....~~ min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Bookkeeper (ret)
(b) General nature of industry, business, or establishment in which employed (or employer)..... Brewing 008

9-BIRTHPLACE, (State or Country), Tournpatrick Ireland

PARENTS.

10-NAME OF FATHER, James Donnelly

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER ?

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos F Donnelly

(Address) 702 Beaumont Ave

15-

Filed ..... OCT 8—1920 ....., 191.....

Registrar.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 7, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2 Oct 1920, to 7 Oct 1920, that I saw h[illegible] alive on 7 Oct 1920, and that death occurred, on the date stated above, at 12.08 pm.

The CAUSE OF DEATH* was as follows:

Nephritis Nephritis

(Duration) 12 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Horace W Byers M. D.

7 Oct., 1920 (Address) 749 N. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, Oct 9th, 1920.

20-UNDERTAKER H Brauneys Sons

ADDRESS 511 N Schroeder St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D47135 HEALTH DEPARTMENT--CITY OF BALTIMORE D47135

CERTIFICATE OF DEATH

154

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 2722 St Paul St.: W WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Mahoney

(Residence in Baltimore: No. 2722 St Paul St.: 83 yrs. 10 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Nov (Month) 28 (Day), 1836 (Year)

7-AGE: 83 yrs. 10 mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: At home (HD)
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE (State or country): Baltimore City

PARENTS

10-NAME OF FATHER: John Mahoney

11-BIRTHPLACE OF FATHER (State or country): N J

12-MAIDEN NAME OF MOTHER: Emma E. Ash

13-BIRTHPLACE OF MOTHER (State or country): U. S.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edw J. Mullen

(Address) 2722 E. Paul St. Balto. Md.

15- Filed OCT 8 - 1920 ROBERT B KRAUTER Burial Permit Issued REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct (Month) 8 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4 yrs ago, 191 , to. Oct 8 1920, that I saw h[er] alive on Oct 6, 1920, and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) 2 yrs. ..... mos. ..... ds

Contributory (SECONDARY) Exhaustion

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) J W Wisner + B C Cathell M. D.

Oct 8, 1920 (Address) 2125 Eutaw 1104 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death				In the State			
Where was disease contracted, if not at place of death?							
Former or usual residence							

19-PLACE OF BURIAL OR REMOVAL: Green Mount Cemetery

DATE OF BURIAL: Oct 11 1920

20-UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47136 HEALTH DEPARTMENT—CITY OF BALTIMORE D.147136

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3204 Brighton ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Conley McAbee

(a) RESIDENCE. No. 3204 Brighton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 20 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Howard O. McAbee

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Rachel H. Brown

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Howard O. McAbee
(Address) 3204 Brighton St.

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1920

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to Oct 6, 1920, that I last saw h.. alive on Oct 6, 1920 and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. 5 mos. — ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) Sidney H. Street M. D.

10/7/1920 (Address) 405 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Oct 9 1920
20 UNDERTAKER	ADDRESS
Zirkler & Zirkler	739 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47137

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47137

91

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Bay View Hospital ST.; WARD)

2-FULL NAME Joseph P. Stahl

(a) RESIDENCE. NO. 1816 Aiken St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 10/2/1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	yrs -	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver D23

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant City Hospital Records
(Address)

15 Filed OCT 8-1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1920

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1920, to Oct 7, 1920 that I last saw him alive on Oct 7, 1920, and that death occurred, on the date stated above, at 9:45 Am.

The CAUSE OF DEATH* was as follows:

Terminal Broncho - Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? N Date of

Was there an autopsy?

What test confirmed diagnosis? clinical observations

(Signed) B. C. Medairy M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetary	10/9 1920
20 UNDERTAKER George J. Pilli	ADDRESS 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Examine carefully. Statements of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

143498
D.47138

HEALTH DEPARTMENT—CITY OF BALTIMORE D.47138

CERTIFICATE OF DEATH.

× 30

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles English.

(a) RESIDENCE. No. Dundee & Eucharist Catonsville ST.: WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 13-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5½		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) md.

PARENTS

10 NAME OF FATHER Edgar English

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Kentucky.

12 MAIDEN NAME OF MOTHER Clarice Guthrie

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant
(Address)

15 Filed OCT 8-1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8 - 1920.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1920, to Oct 8, 1920, that I last saw him alive on Oct. 8, 1920, and that death occurred, on the date stated above, at 12 05 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Lumbar puncture & Smear

(Signed) W Davison, M. D.

, 19 (Address) 1 H H. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincent's Cemetery

DATE OF BURIAL 10/8/1920.

20 UNDERTAKER George J. Puth

ADDRESS 1735 Hanford Ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Bryan

D.47139

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47139

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1644 Carswell St. WARD) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Premature Birth Bryan

(Residence in Baltimore: No. 1644 Carswell st St.; ..... yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. October 8 1920
(Month) (Day) (Year)

7-AGE. one hour

..... yrs. ..... mos. ..... da.

If LESS than 1 day, One hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). 1644 Carswell st Baltimore Md

PARENTS.

10-NAME OF FATHER. Hadey Bryan

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Marie Kampad

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed ..... Oct 8 ..... 1920 Robert P. Harrison, Registrar.

OCT 8-1920

Burial Permit Clerk.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 8, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191 ..., to Oct 8 1920, that I saw him alive on Oct 8 1920, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

2.30 am
Premature Birth
one hour (Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Premature Birth
one hour (Duration) ..... yrs. ..... mos. ..... da.

(Signed) Raymond Westbrook M. D.

Oct 8, 1920 (Address) 668 Fordham Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore County	Oct 8, 1920
20-UNDERTAKER	ADDRESS
George J. Ruth	1735 Hanford Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47140 HEALTH DEPARTMENT—CITY OF BALTIMORE D-47140

CERTIFICATE OF DEATH. X 20

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1829 Lorman St. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Lee Myers.

(a) RESIDENCE. No. 1829 Lorman St. ST., WARD. Petersburg Va.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/6/1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	11	2	

8 OCCUPATION OF DECEASED 040

(a) Trade, profession or particular kind of work Laboress

(b) General nature of industry, business, or establishment in which employed (or employer) Made fire works

(c) Name of employer Va. Fire Works Co.

9 BIRTHPLACE (city or town) (State or country) Petersburge Va.

PARENTS

10 NAME OF FATHER Thomas Myers.

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Va.

12 MAIDEN NAME OF MOTHER Matilda Claton

13 BIRTHPLACE OF MOTHER (city or town) Petersburge (State or country) Va.

14 Informant Mrs. Emma Grammer (Address) 1829 Lorman St.

15 Filed OCT 8-1920 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/7/'20. 19

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4th. 1920, to Oct. 8th. 19 2p, that I last saw her alive on Oct. 8th. 1920. 19 , and that death occurred, on the date stated above, at 1:40 a.m.

The CAUSE OF DEATH* was as follows:

Septicemia.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Abcess of third upper mollar tooth (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Petersburge Va.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson M.D. M. D.

10-8 1920 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Petersburg Virginia	10-9 1920
20 UNDERTAKER Sam'l H. Chase & Son	ADDRESS 1400 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47141

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47141

CERTIFICATE OF DEATH.

4 | V

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital W. WARD)

2-FULL NAME Miss Ada Eader

(a) RESIDENCE. No. 3031 St. Paul Street WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) April 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housekeeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " " "

12 MAIDEN NAME OF MOTHER " " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " " "

14 Informant Mrs. C. Stafford
(Address) 3031 St. Paul St

15 Filed ..... 19 Robert P. Harrison,
Registrar
OCT 8 - 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-8 19 20

17 I HEREBY CERTIFY, That I attended deceased from 9-10-, 19 20, to 10-8, 19 20
that I last saw h alive on 10-8, 19 20,
and that death occurred, on the date stated above, at 1:00 p.m.
The CAUSE OF DEATH* was as follows:
Carcinoma of rectum

(duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Hypertrophied Decompensation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-1-20

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) H. Whitridge, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	10/11 1920
20 UNDERTAKER	ADDRESS
William Cook	502 E Fait

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D.47142

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47142

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1522 Baker ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florance E. Randall.

(a) RESIDENCE. NO. 1522 Baker St ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female.

4 COLOR OR RACE white.

5 Single, Married, Widowed, or Divorced (write the word) married.

5a If married, widowed or divorced HUSBAND of (or) WIFE of John T Randall

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years 43 — Months 1877 May — Days 22 — If LESS than 1 day, hrs. or min. 15 —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jew. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Alexander Ruben

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Hammond.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John T. Randall (Address) 1522 Baker

15 Filed CT 8-1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-7 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 30 1920, to Oct 7 1920 that I last saw h[illegible] alive on Oct 7 1920 and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs 8

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. R. Mullen M. D.

19[illegible] (Address) 2757 Monroe a.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Woodlawn

DATE OF BURIAL — Oct 9 19

20 UNDERTAKER — William Cook

ADDRESS — 502 Hall

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47143 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47143

CERTIFICATE OF DEATH.

REGISTERED No. C 782

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2141 Chelsea Terrace ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry L. Johnson

(Residence in Baltimore: No. 2141 Chelsea Terrace St.; Lifetime yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Nov 6th, 1885. (Month) (Day) (Year)

7-AGE. 34 yrs. 11 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Harry C. Johnson

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Annie Lauderman

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). George L. Kirwan

(Address). 2141 Chelsea Terrace

15-

Filed. OCT 8 1920, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 7th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 20 1920, to Oct 7 1920, that I saw h.m alive on Oct 7 191, and that death occurred, on the date stated above, at 11 25 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.
Tuberculous pneumonia.

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(Duration) ? yrs. mos. ds.

(Signed) Walter S. Hublett M. D.

Oct 8, 1920 (Address). 340 2 E Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Lorraine Cemetery	Oct 11, 1920
20-UNDERTAKER. H. Allen Hutter	ADDRESS 3517 Springdale Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact place of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~4366~~ D-47144 D-47144

CERTIFICATE OF DEATH.

76

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. Johns Hopkins Hospital ST. (or WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Poole

(a) RESIDENCE. No. 1508 N Dallas St. ST. Baltimore Md WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 3-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Poole

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Lucile Haines

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant J. T. H.
(Address)

15 Filed OCT 8-1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8 - 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct. 7 -, 1920, to Oct. 8 -, 1920, that I last saw h~~im~~ alive on Oct. 8 -, 1920, and that death occurred, on the date stated above, at 6 A.M. m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis
Type III Pneumococcus

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Otitis media

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Lumbar puncture & Culture

(Signed) C. W. Harrison, M. D.

, 19 (Address) J H H Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Oct-9 1920
20 UNDERTAKER Mrs Robert A Ellis	ADDRESS 725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.47145 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47145

CERTIFICATE OF DEATH. X-104

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 14-9th. St. Fairfield. St.; 25 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernice L. White.(C)

(Residence in Baltimore: No. 14-9th. St. Fairfield. St.; yrs., mos. 5 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored	Single

6-DATE OF BIRTH, September 27th. 1919, 1 (Month) (Day) (Year)

7-AGE, 1 yrs. -- mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Calvert Co. Md.

PARENTS.

10-NAME OF FATHER, James White(C)

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co. MD.

12-MAIDEN NAME OF MOTHER Helen Hanson(C)

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen White.C (mother)

(Address) 824 Silver St. Philadelphia

15-

Filed OCT 8 1920, 191 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 7th. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry. (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis.

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) Otto K. Reinhardt M. D. (Coroner)

Oct 7th. 1920, (Address) 1017 S. Charles S.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

824 Silver St.

Former or usual residence Philadelphia, Pa.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Dukes W.L. Calvert Co. Md.	Oct 8, 19..D
20-UNDERTAKER John H. Toadvine	ADDRESS 1424 West St

N.B.—Information should be carefully supplied. ACCURATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47146

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47146

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25 Somerset Rd ST.; 27 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Hubbard

(Residence in Baltimore: No. 25 Somerset Rd St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, January (Month) 22 (Day), 1874 (Year)

7-AGE,	If LESS than 1 day,
46 yrs. 7 mos. 16 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Pres. of Md Trans. Co
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

9-BIRTHPLACE, (State or Country), Del.

PARENTS.

10-NAME OF FATHER, Wm T. Hubbard

11-BIRTHPLACE OF FATHER (State or Country), Caroline Co. Md

12-MAIDEN NAME OF MOTHER Sarah Wiley

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louisa B. Hubbard

(Address) 25 Somerset Rd

15-

Filed OCT 8 1920, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact abbreviations of words may be used if important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 7 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1919, to Oct 7" 1920, that I saw h~~is~~ alive on Oct 7" 1920, and that death occurred, on the date stated above, at 11.20 a.m.

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia

(Duration) 1 yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) Complications, Nephritis

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) H. L. B. Harrison M. D.

Oct 8, 1920 (Address) 1107 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge	Oct 9, 1920

20-UNDERTAKER	ADDRESS
J. O Mitchell	1201 W Baltimore St

Spec.—8-24-14—M. & T.—2000 Bks.

D. 47147 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 47147

CERTIFICATE OF DEATH.

90 V

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1938 Linden Ave ST.; 14th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lydia L. Gilbert

(Residence in Baltimore: No. 1938 Linden Ave St.; 15 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widowed

6-DATE OF BIRTH, February (Month) 19th (Day) 1844 (Year)

7-AGE,	If LESS than 1 day,
76 yrs. 7 mos. 19 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

9-BIRTHPLACE, (State or Country), Havre de Grace Md

PARENTS.

10-NAME OF FATHER, Samuel Lawder

11-BIRTHPLACE OF FATHER (State or Country), Harford Co. Md

12-MAIDEN NAME OF MOTHER Eliza Miller

13-BIRTHPLACE OF MOTHER (State or Country), Harford Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nora Gilbert

(Address) 1938 Linden Ave

15-

Filed ....., 191.... Robert P. Harrison Registrar.

OCT 8 - 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 8th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 28 1920, to Oct 8th 1920, that I saw h[er] alive on Oct 8th 1920, and that death occurred, on the date stated above at 9.40 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

several (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chr Bronchitis

several (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J W Keown M. D.

Oct 8th, 1920 (Address) 1938 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Havre de Grace Md	Oct 11, 1920

20-UNDERTAKER	ADDRESS
J O Mitchell	1201 W Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... DEATH is very important. See instructions on back of certificate.

D.47148 HEALTH DEPARTMENT--CITY OF BALTIMORE D.47148

CERTIFICATE OF DEATH

37V

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2310 N. Calvert St. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Francis Albert Kurtz

(Residence in Baltimore: No. 2310 Calvert St. St.: 66 yrs. ... mos. ... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~SINGLE~~, MARRIED, ~~WIDOWED~~ OR DIVORCED (Write the word)
Male	White	married.

6 DATE OF BIRTH October 5, 1854 (Month) (Day) (Year)

7 AGE 66 yrs. — mos. — ds. | If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER F. Newton Kurtz.

11 BIRTHPLACE OF FATHER (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Julia Grafton

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. P. Kurtz

(Address) Robert E. ...

15 Filed OCT 8 - 1920, 191 Burial Permit Clerk.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 7, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1920, to October 1, 191—, that I saw him alive on Oct 7th, 1920, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis dyratim many years. Immediate Dilated heart.

(Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Jas. M. Craighill M. D.

Oct. 8, 1920 (Address) 1800 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Green Mount | DATE OF BURIAL Oct 11, 1920

UNDERTAKER J. O'M. Cahill | ADDRESS 1201 W. Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

D.47149

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47149

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 631 W Lexington St WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn M Hood

(Residence in Baltimore: No. 631 W Lexington St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Aug (Month) 4 (Day), 1920 (Year)

7-AGE, ...yrs. 2 mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Walter R. Hood

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Margaret H. Ellis

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter R. Hood

(Address) 631 W. Lexington

15-

Filed ..... 191.... Robert P. Harrison, Registrar.

OCT 8-1920

Burial Permit Clerk.]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 8 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 7 1920, to Oct 8 1920, that I saw her alive on Oct 7 1920, and that death occurred, on the date stated above, at 9 1/2 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Broncho

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) P. L. Joslin M. D.

Oct 8, 1920. (Address) 532 W. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden — DATE OF BURIAL, Oct 9, 1920

20-UNDERTAKER Cherrow & Son — ADDRESS Chestnut Ave

D.47150 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47150

CERTIFICATE OF DEATH.

REGISTERED No. C. 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. John Hopkins Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chalmer C. Jones

(Residence in Baltimore: No. 3707 Mt. Pleasant ave St. 4 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, December 28, 1887
(Month) (Day) (Year)

7-AGE, 32 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Ala.

PARENTS.

10-NAME OF FATHER, Lee Jones.

11-BIRTHPLACE OF FATHER (State or Country), Alabama

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Doshie E. Jones

(Address) 3707 Mt. Pleasant Ave

15- Robert P. Harrison,

Filed OCT 8 1920, 191

Burial Permit Clerk Registrar.

Dr. Smith 2421 E. Balt. St.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 7, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

, 191 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	Oct 11, 1920
20-UNDERTAKER William Cook	ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47151 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2018 Thomas Ave ST.; 15 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Lindsey

(Residence in Baltimore: No. 2018 Thomas Ave St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Oct (Month) 8 (Day), 1920 (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, 2 hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General natnre of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), 1820 Thomas Ave. Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Lindsey

11-BIRTHPLACE OF FATHER (State or Country), Iowa

12-MAIDEN NAME OF MOTHER Minnie Taylor

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. John C. Lindsey

(Address) 1820 Thomas Ave

15-

Filed....., 191... Robert P. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 8 (Day), 1920 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Oct 8 1920, to Oct 8 1920, that I saw her alive on Oct 8 1920, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Blue baby.
Failure Foramen Ovalae Failed to Close. 9hrs
(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Blue baby. 9hrs
(Duration) ....yrs....mos....ds.

(Signed) W. S. Niblett M. D.
Oct 8, 1920 (Address) 3902 Clifton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Forrests Cemetery — DATE OF BURIAL, Oct 9, 1920

20-UNDERTAKER Jos Jourdens & Son — ADDRESS 217 S. Paca St

important. See instructions on back of certificate.

[Permit Clerk.]

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47152 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47152

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2341 Edmonson Ave. WARD 20)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna. Kaufmann

(a) RESIDENCE (Usual place of abode) NO. 2341 Edmonson Ave WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Adolfich Kaufmann

6 DATE OF BIRTH (month, day, and year): March 13 1844

7 AGE: Years 76 Months 7 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Adolfich Kaufmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dent Flenner

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Frank L. Hennig (Address) 2341 Edmonson Ave

15 Filed ..... 19 ..... Registrar

Robert P. Harrison

OCT 8—1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st 1919, to Oct 6th 1920, that I last saw her alive on Oct 6th 1920, and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank N. Dilley, M. D.

, 19 (Address) 2338 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 11 19 20
20 UNDERTAKER	ADDRESS
Jos Joerden & Son	207 S. Pine

CAUSE OF DEATH must be plainly stated, and the certificate properly filled out on back of certificates. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 47153 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 47153

CERTIFICATE OF DEATH.

79

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 W. Conway ST.; W WARD)

2-FULL NAME Margaret Marshall

(a) RESIDENCE. NO. 607 W. Conway ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 9 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed,~~ or ~~Divorced~~ (write the word)
Female	white	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	9	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John. McMiller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Edwin D. Woodall
(Address) 607 W. Conway St

15 Filed OCT 8-1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1920, to Oct 6, 1920, that I last saw her alive on Oct 6 1920, and that death occurred, on the date stated above, at 11 0 m.

The CAUSE OF DEATH* was as follows:

1 Hemorrhage from Stomach
and Exhaustion
2 Cancer of Stomach
Contributory (Secondary) Old Age (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) C. Klapp M. D.

19 (Address) 1215 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Oct 9 1920
20 UNDERTAKER	ADDRESS
Jos Jorsdens & Son	2178 Pacific

CAUSE OF DEATH plainly, and TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47154 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47154

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14th Belt ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Martin

(a) RESIDENCE. NO. 14th Belt ST., 24 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 11 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frank Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Roma "

12 MAIDEN NAME OF MOTHER Emma M. Trueblood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Emily Martin
(Address) 14th & Belt

15 Filed OCT 9 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-7- 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1 1920, to Dec. 5 2 1920, that I last saw him alive on Dec. 5 2 1920, and that death occurred, on the date stated above, at 11 40 A m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dr Hamilton

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I. D. Hoppard, M. D.

, 19 20 (Address) 423 E. Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Oct 8 1920
20 UNDERTAKER	ADDRESS
Wm J E Evans Son	1428 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47155

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47155

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 St Ann's ave ST.; 9 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H Brandt

(Residence in Baltimore: No. 613 St Ann's ave St.; ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Oct 5, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 3 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John H Brandt

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Elizabeth H Cook

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H Brandt

(Address) 613 St Anns ave

15-

Filed OCT 9 1920, 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 8, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1920, to Oct. 8, 1920, that I saw him alive on Oct. 7, 1920, and that death occurred, on the date stated above, at 89 m.

The CAUSE OF DEATH* was as follows:

Pneumonia & Tuberculosis

..... (Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

Oct 8, 1920 (Address) 1206 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Oct 9, 1920

20-UNDERTAKER Robt P Harrison

ADDRESS 1424 Pony

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.47156 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47156

CERTIFICATE OF DEATH. 114

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.; WARD)

2-FULL NAME Mrs. Budget Costello

(a) RESIDENCE. NO. 1344 Sargent ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Since mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel J. Costello

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John. Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Daniel J. Costello

(Address) 1344 Sargeant

15 Filed OCT 5 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8, 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 25, 1920, to Oct 8, 1920,

that I last saw h[illegible] alive on Oct 5, 1920,

and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis-

(duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) Obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Sept. 19, 1920

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Lyman A. Abbott, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Paul. Arlington. Cem. Boston Mass

DATE OF BURIAL Oct 11, 1920

20 UNDERTAKER John J. Cannon & Son

ADDRESS 501 Hollins St.

CAUSE OF DEATH. Please write plainly in ink, and without abbreviations. See instructions on back of certificates.
TION is very important.

Certificate
47156

MUNICIPAL DEPARTMENTS

HEALTH DEPARTMENT

Office of John K.Cowan & Sons,
Funeral Directors,
901 Hollins street.

C.Hampson Jones,M.D.
Commissioner of Health,
Baltimore,Md.

Dear Sir:

On October 9th,1920, I filed with the burial permit clerk of the Health Department, the death certificate of Mrs. Bridget Costello, who died on October 8th,1920. In that portion of the certificate giving the nativity of the parents of the deceased, instead of stating the birthplace to have been Ireland it was given as Baltimore,Md. Also, the age should have been 40 years instead of 40 years, and the length of residence 6 years instead of life time. I therefore respectfully ask that you make the desired changes in the certificate, as this is especially requested by the relatives in order to collect the insurance due the estate of the deceased.

John. Cowan & Sons
Per J.J.Co

SON JONES, M. D.
COMMISSIONER
ERICK HEMPEL, M. D.
ASSISTANT COMMISSIONER
GAN, M. D.
ASSISTANT COMMISSIONER
ITHER,
SECRETARY

CITY OF BALTIMORE
MARYLAND
MUNICIPAL DEPARTMENTS

HEALTH DEPARTMENT

October 21, 1920.

Certificate 47156

Mr. A. D. Thompson,
Registrar's Clerk.

Dear Mr. Thompson:-

In accordance with instructions received from the City Solicit
in a letter dated October 21st in the case of changing the certificate of death
of Mrs. Bridget Costello in certain particulars pertaining to her personal and
statistical data:

I direct you to permit the undertaker, John K.Cowan & Sons, to
make such changes as they have been directed to do, provided that John K.Cowan
Sons give you a letter stating that such changes in the certificate have been m
by them and signed by the one who makes the change.

The letter of instructions from the City Solicitor is placed in
file with references for future use if necessary.

Yours respectfully,

C. Hampson Jones
Commissioner of Health.

CHJ/M

Thank You

Certificate 47156

Name of Deceased -- Bridget Costello

Date of Death -- October 8, 1920.

Age of Deceased -- 44

Color - Sex - Civil Condition -- White - Female - Married

Occupation - Housework

Nativity of Parents (Father — Ireland) (Mother — Ireland.)

Birthplace of Deceased — Ireland

Duration of Residence in Baltimore { City (6) years.

Place of Death (Franklin Square Hospital)

Residence of Deceased — 1344 Sargeant St

Cause of Death - Cholelithiasis - Exhaustion

Duration of Last Sickness - 1 mo - 13 days

Place of Burial — St. Paul's cemetery - Arlington Mass.

Medical Attendant - Lyman Abbott M.D.

Undertaker - John J. Corcoran Son.

619-2-1-19—D. H. S.—5000 P.

Clerk of Registrar

Spec.—6-9-19—H. P. Co.—1000 Bks.

29.47157 HEALTH DEPARTMENT—CITY OF BALTIMORE 29.47157

CERTIFICATE OF DEATH.

8

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1356 Carroll ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hilda Anderson

(a) RESIDENCE. No. 1356 Carroll ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 11 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 18 Oct 1919

7 AGE	Years	Months	Days	If LESS than 1 day. hrs. or min.
	0	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Henson Anderson

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Josephine Roy

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Josephine Roy
(Address) 1356 Carroll St

15 Filed OCT 9 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1920, to Oct 7, 1920, that I last saw her alive on Oct 6, 1920, and that death occurred, on the date stated above, at 12.5 A. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dorsey Hoag, M. D.

10/8, 1920 (Address) 729 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Oct 9 1920
20 UNDERTAKER	ADDRESS
Brown & Freeland	Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. The statement of OCCUPATION is very important. See instructions on back of certificates.

alto H D47157 Oct 7. 1920

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Co

Brand and Freeland.

D47158

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47158

CERTIFICATE OF DEATH.

167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1936 Light St. ST.: 23 (WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gladys A. Thomas.

(Residence in Baltimore: No. 1936 Light St.

St.; yrs. 4 mos. 8 ds. 28.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Single.

6-DATE OF BIRTH, January 8th, 1916, 1
(Month) (Day) (Year)

7-AGE, 4 yrs. 8 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Frank C. Thomas.

11-BIRTHPLACE OF FATHER (State or Country). Sykesville, Md.

12-MAIDEN NAME OF MOTHER Susie Horton.

13-BIRTHPLACE OF MOTHER (State or Country). Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank C. Thomas. (father)

(Address) 1936 Light St.

15-

Filed ....., 191.....

Registrar.

OCT 9 1920

Robert P. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 6th, 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry.
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns about the face & body.
Accidentally burned while playing with fire.

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Oct. 6th., 191.20 (Address) 1617 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, Oct 9, 1920

20-UNDERTAKER Margaret G. Flynn ADDRESS 1427 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47159 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47159

150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 N. Streeper ST.; 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irvan Van Kershaw

(a) RESIDENCE. NO. 424 N. Streeper ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Oct 4 '20

7 AGE — Years | Months | Days: 4 | If LESS than 1 day, ...hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business, or establishment in which employed (or employer): ✓ 000

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Chas Van Kershaw

11 BIRTHPLACE OF FATHER (city or town) (State or country): Alabama

12 MAIDEN NAME OF MOTHER: Mary E. Listner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Chas Van Kershaw

(Address) 424 N. Streeper

15 Filed OCT 9 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 8, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1920, to Oct 8, 1920, that I last saw him alive on Oct 8, 1920, and that death occurred, on the date stated above, at 4-30 P. m.

The CAUSE OF DEATH was as follows:

Dr Entity

Foramen Ovale not closed

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) W. L. Fair M. D.

Oct. 1920 (Address) 12 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Oct 9 1920
20 UNDERTAKER: Lilly & Zeiler	ADDRESS: 403 S. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blc.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

W3044
D. 47160

D. 47160 ✓

X 45

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 17th WARD)

2-FULL NAME Mr. James C. Mc Manigle.

(a) RESIDENCE. NO. Johnsonburg Pa. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2 - 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Johnsonburg Pa

PARENTS

10 NAME OF FATHER Alexander Mc Manigle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Juliette Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant (Address)

15 Filed OCT 9 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1920, to Oct. 7 - 1920, that I last saw him alive on Oct 7 - 1920, and that death occurred, on the date stated above, at 9.05 P m.

The CAUSE OF DEATH* was as follows:

Cancer of prostate.
Acute cardiac dilatation.
Embolism.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Gailey, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johnsonburg Pa	Oct 8 19 20
20 UNDERTAKER H E Hughes	ADDRESS 1708 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47161 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47161

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 122 King Court (ST.;) 4 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwina Loomis

(a) RESIDENCE. No. 122 King Court ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Oct 24 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Douglass Warren

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Drusia Garrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Francis Stewart (Address) 613 Fennell st

15 Filed OCT 6 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 19 20

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 19 20, to Oct 7, 19 20, that I last saw h[illegible] alive on Oct 7, 19 20, and that death occurred, on the date stated above, at 10.20 p m.

The CAUSE OF DEATH* was as follows: OVER

acute Pulm Tuberculosis

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Knight, M. D.

19 (Address) 6 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int Antrim Co	Oct 10 19 20

20 UNDERTAKER Wm Scott Hooper ADDRESS 706 Cathedral st

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.47162 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47162

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3241 O'Donnell St.; 1 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wiktoria Gosciuska

(a) RESIDENCE. No. 3241 O'Donnell St., 1 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Dec. 22, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Peter Gosciuska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Jawidja Wozniak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Peter Gosciuski

(Address) 3241 O'Donnell St

15 Filed OCT 9 1920, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-7 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1920, to Oct 7, 1920, that I last saw h[illegible] alive on Oct 7, 1920, and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis and dilated heart (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? 1003 S. Kenwood ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J. McAvoy M. D.

Oct 8, 1920 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Oct 11 1920
20 UNDERTAKER Stephen J Fialkowski	ADDRESS 1111 S Hanover

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1947163 HEALTH DEPARTMENT—CITY OF BALTIMORE 1947163

CERTIFICATE OF DEATH. 119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 Tarrest ST.: 5th WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Rippy

(a) RESIDENCE. No. 303 Tarrest ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF DISEASE OR CONDITION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Rippy

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pilsdriver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER John Rippy

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Mollie Jennins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Annie Rippy
(Address) 303 Tarrest St

15 Filed OCT 10 1920 19 ROBERT J. FRAUTEN Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1920, to Oct. 8, 1920, that I last saw him alive on Oct. 8, 1920, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Oedema of lungs associating uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Exam. of urine

(Signed) Robert J. Green M. D.

10. 9. 1920 (Address) 120½ Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shelby N. C.	10/10/20.
20 UNDERTAKER	ADDRESS
Sam'l Kennedy.	570 N Bridge

Spec.—8-24-14—M. & T.—2000 Bks.

1047164 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 1047164

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 N Dallas ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Peroutka

(Residence in Baltimore: No. 825 N Dallas St.; 21 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct (Month) 1 (Day) (Year)

7-AGE, 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer) Own

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, John Peroutka

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Peroutka

(Address) 825 N Dallas St

15- OCT 10 1920 ROBERT B KRAUTER

Filed, 191 Registrar.

Burial permit issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 7 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15 1920, to Oct 7 1920 that I saw h[illegible] alive on Oct 7 1920, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Cardiac

(Duration) yrs. mos. 1 ds.

(Signed) W Murphy M. D.

10-10, 1920 (Address) 20 W Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Hill — DATE OF BURIAL, Oct 10, 1920

20-UNDERTAKER Frank Grach & Son — ADDRESS 1706 Aisquith

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47165 HEALTH DEPARTMENT—CITY OF BALTIMORE D47165

CERTIFICATE OF DEATH.

78 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1241 W. Baltimore St 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph Katz

(a) RESIDENCE. No. 1241 W. Balto ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lilly Katz

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 54 | Months – | Days – | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Haberdasher

(b) General nature of industry, business, or establishment in which employed (or employer): " " 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Jeus Katz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Bertha Metzger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Lewis Katz
(Address): 1241 W Balto St

15 Filed OCT 10 1920 ROBERT B. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 9 1920

17 I HEREBY CERTIFY, That I attended deceased from June 21 19 20, to Oct 9 19 20, that I last saw him alive on Oct. 9 19 20, and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

Septic endocarditis
(Streptococcus septicemia)
(duration) ....yrs. 4 mos. ....ds.

CONTRIBUTORY (Secondary): Myocarditis
(duration) ....yrs. ....mos. 7 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? Clinical + lab tests

(Signed) J. Frederick Leuly, M. D.

10/9, 1920 (Address) 7080 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship — DATE OF BURIAL: Oct 11 1920

20 UNDERTAKER: J. Ahrens & Co — ADDRESS: 1611 Madison

D47166 HEALTH DEPARTMENT—CITY OF BALTIMORE D47166

CERTIFICATE OF DEATH.

175-001

1 PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital St. 13 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Clarence E. Rigley

(Residence in Baltimore: No. 1223 Dellwood Ave St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, June (Month) 14 (Day), 1905 (Year)

7-AGE, 12 yrs. 3 mos. 24 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Scholar
(b) General nature of industry, business, or establishment in which employed (or employer): NO

9-BIRTHPLACE, (State or Country): Baltimore City

PARENTS.

10-NAME OF FATHER: William J. Rigley

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Clara E. Mullen

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William J. Rigley
(Address) 1223 Dellwood Ave

15- Filed OCT 10 1920, 191.... BOBBEY B KRAUTER Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 8 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
Auto Accidental
(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Shock
(Duration) yrs. mos. ds.

(Signed) Geo L. Blades M. D.
(Coroner.)
10/10/ 1920 (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: New Cathedral — DATE OF BURIAL: Oct 11, 1920

20-UNDERTAKER: A. Marshall — ADDRESS: 3539 Gill Rd

647167 HEALTH DEPARTMENT—CITY OF BALTIMORE 647167

CERTIFICATE OF DEATH.

REGISTERED No. C 182

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Annapolis Road, Westport. ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Pattingill.

(Residence in Baltimore: No. Annapolis Road, Westport. St.; yrs. 40 mos. ---- ds. ----)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH, Do not know. (Month) (Day) 1 (Year)

7-AGE, 40 yrs. ---- mos. ---- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Ephriam Pattingill.

11-BIRTHPLACE OF FATHER (State or Country), Mass.

12-MAIDEN NAME OF MOTHER Katie Scott.

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen Strulz.

(Address) Annapolis Road Westport.

15- Filed OCT 10 1920, 191.... ROBERT B KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 6th. 1920. (Month) (Day) 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest & autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest & autopsy (Inquest, autopsy or inquiry.) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage.
Due to pistol shot wound in the side.
Homicide.
(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs....mos....ds.

(Signed) Otto F. Reinhardt M. D. (Coroner.)

Oct. 9th., 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	Oct. 11, 1920
20-UNDERTAKER William Cook	ADDRESS 2325 Hatton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

947168 HEALTH DEPARTMENT—CITY OF BALTIMORE 947168

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1624 McElderry ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Palmer.

(a) RESIDENCE. No. 1624 McElderry ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Palmer

6 DATE OF BIRTH (month, day, and year) Oct 8 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Geo Palmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unkown

14 Informant Mary Palmer
(Address) 1624 McElderry

15 Filed OCT 16 1920 ROBERT E KRAMER Registrar
Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1920, to Oct 8, 1920, that I last saw h[illegible] alive on Oct 7, 1920, and that death occurred, on the date stated above, at 4.50 p.m.

The CAUSE OF DEATH* was as follows:

Pleurisy and Pericarditis

Acute

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Schizophrenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 8

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical History

(Signed) W. C. Burns, M. D.

(Address) 2218 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Oct 11 1920
20 UNDERTAKER William Cook	ADDRESS 502 E Hoff Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of cause TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47169 HEALTH DEPARTMENT—CITY OF BALTIMORE D47169

CERTIFICATE OF DEATH. 37

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew J. Evans

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records. (Address): New City Hospital.

15 Filed OCT 10 1920 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 8, 1920

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1919, to October 8, 1920, that I last saw him alive on October 8, 1920, and that death occurred, on the date stated above, at 5:25 P. M.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis (no cerebral hemorrhage.)

2 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebro-spinal syphilis

2 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wasserman

(Signed) Wasserman, M. D.

10/9/ 1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Oct 12 1920
20 UNDERTAKER: William Cook	ADDRESS: 522 S. Hurd St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered if certificate is to be complete. Data for Items 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 and 14 may be obtained from informant. Items 15 and 16 must be answered by physician. Item 17 must be signed by physician. Item 18 must be answered by physician if death occurred in a hospital or institution. Item 19 must be answered by undertaker. Item 20 must be signed by undertaker. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047170

HEALTH DEPARTMENT—CITY OF BALTIMORE

120 047170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 232 S. Spring St.; 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Saunders

(a) RESIDENCE. NO. 232 S. Spring St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriet Saunders

~~Husband~~

6 DATE OF BIRTH (month, day, and year) aug. 10 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
39	years	days	07	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer.

(b) General nature of industry, business, or establishment in which employed (or employer) Dr

(c) Name of employer Thos Jackson

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thos. Saunders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Sarah Saunders (Address) 232 S. Spring St

15 Filed OCT 10 1920 ROBERT T. KRAUTER Registrar

Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1920, to Oct. 7, 1920, that I last saw h[im] alive on Oct. 6, 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows: Chronic interstitial nephritis

(duration) yrs. 8 mos. 0 ds.

CONTRIBUTORY (Secondary) Mitral regurgitation

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. W. Robinson M. D.

(Address) 1532 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodbury Cemetery	Oct 10 1920
20 UNDERTAKER	ADDRESS
Milton Davis	413 N. Eden St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

047171

HEALTH DEPARTMENT—CITY OF BALTIMORE

047171

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 939 Bevan ST.: 22 WARD)

2-FULL NAME Samuel Limina

(a) RESIDENCE. NO. 939 Bevan ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 6-1920

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or ~~town~~) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Anthony Limina

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Ethel Powell

13 BIRTHPLACE OF MOTHER (city or ~~town~~) Baltimore
(State or country) Md

14 Informant Ethel Limina
(Address) 939 Bevan St

15 Filed ....., 19..... Registrar

OCT 10 1920 Postal Telegraph Cable Co.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1920, to Oct. 8, 1920, that I last saw h... alive on Oct. 8, 1920, and that death occurred, on the date stated above, at 6.30p m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Intestinal Intoxication.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No. None.

What test confirmed diagnosis? .....

(Signed) Henry Haeb Clements M. D.

(Address) 933 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent Cem	Oct 11 1920
20 UNDERTAKER	ADDRESS
Wash Tatem	Somerset Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

047172 HEALTH DEPARTMENT—CITY OF BALTIMORE 047172

CERTIFICATE OF DEATH.

150

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1350 Calhoun ST.; 15 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Jasper Welty

(Residence in Baltimore: No. 1350 N Calhoun St.; yrs., mos. 1 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, October 9, 1920 (Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 1 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Own Family

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Jasper Welty

11-BIRTHPLACE OF FATHER (State or Country), Whitestone Va

12-MAIDEN NAME OF MOTHER Mossie Wright

13-BIRTHPLACE OF MOTHER (State or Country), Gilmennock Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jasper Welty

(Address) 1350 Calhoun St.

Filed OCT 10 1920, 191.... ROBERT B. ERAUTER Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 9, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patient found unconscious

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Hennessy M. D. (Coroner.)

Oct. 9, 1920 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery

DATE OF BURIAL, Oct 9, 1920

20-UNDERTAKER Edw. Kruggold

ADDRESS 1463 Carey St

Spec.—6-9-19—H. P. Co.—1000 Bks.

047173

HEALTH DEPARTMENT—CITY OF BALTIMORE

047173

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1328 N Calhoun ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Robert Holly

(a) RESIDENCE. No. 1328 N. Calhoun ST., WARD. St Marys Co Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) St Marys Co.

PARENTS

10 NAME OF FATHER John Holly

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co.

12 MAIDEN NAME OF MOTHER Milson Curtis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co

14 Informant Anna Hucks

(Address) 1328 N. Calhoun St

15 Filed OCT 10 1920 ROBERT B. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1920, to Oct 9, 1920, that I last saw h— alive on Oct 8, 1920, and that death occurred, on the date stated above, at 12.40 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(duration) 1 yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? St Marys Co

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Urinalysis

(Signed) W. H. Wright M. D.

(Address) 1209 Prestman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
McCordsville Md	Oct 11 1920
20 UNDERTAKER JAMES H. DENNIS	ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47174 HEALTH DEPARTMENT—CITY OF BALTIMORE D47174

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1916 Christian ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A Howard

(a) RESIDENCE. No. 1916 Christian ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1858 July 20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington Co

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington Co

14 Informant Mrs Williams

(Address) 1916 Christian st

15 Filed OCT 10 1920 19 ROBERT P. BRAUER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1920, to Oct 7, 1920, that I last saw him alive on Oct 7, 1920, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH was as follows:

Intestinal Nephritis

Endocarditis

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Robert C Mitsch M. D.

10-9 1920 (Address) 2151 Hollins ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 11 1920
20 UNDERTAKER	ADDRESS
John J Fields	1200 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1047175 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047175

CERTIFICATE OF DEATH.

REGISTERED NO. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1432 Woodall st. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Natalie Marie Dudeck

(Residence in Baltimore: No. 1432 Woodall st. St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Aug. 20/1919, 1 (Month) (Day) (Year)

7-AGE, 1 yrs. 1 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Frederick Dudeck

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Catharine Merzendorf

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catharine Dudeck

(Address) 1432 Woodall st.

15- Filed OCT 10 1920 191 ROBERT E. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 9/20, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 15/20 191, to Oct 9/20 191, that I saw her alive on Oct. 9/20. 191, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Intoxication

(Duration) ... yrs. ... mos. 21 ds.

CONTRIBUTORY (Secondary) /

(Duration) ... yrs. ... mos. ... ds.

(Signed) Louis Theodor Quinn M. D.

Oct. 8/20 191... (Address) 933 Hanover.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Oct 11, 191.2

20-UNDERTAKER Margaret E. Flynn ADDRESS 1417 Light St.

Check off items as they are important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1947176 1947176

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 104

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Bohr

(a) RESIDENCE. No. 18 S Arlington St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER James Bohr

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Pearl Jones

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Hospital Record
(Address) H. H.

15 Filed OCT 10 1920, 19 ROBERT B. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9th 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 6th, 1920, to Oct 9th, 1920, that I last saw h[illegible] alive on Oct 9th, 1920 and that death occurred, on the date stated above, at 2 40 a. m.

The CAUSE OF DEATH* was as follows:

Diarrhea (not dysentery)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible] Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Edenton Md.	Oct 11 19 20
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 Balto St

TION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

047177 HEALTH DEPARTMENT—CITY OF BALTIMORE 047177

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH General German Aged Peoples Home REGISTERED NO. C

CITY OF BALTIMORE: (No. ... ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Miller

(Residence in Baltimore: No. N.E. Cor Baltimore and Payson Sts St.: 79 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Sept 12, 1837. (Month) (Day) (Year)

7-AGE, 83 yrs. — mos. 28 ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... Baker
(b) General nature of industry, business, or establishment in which employed (or employer) ... Retired 03

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Daniel Miller

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dora Kirkner

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Records German Aged Home

(Address) Balto & Payson St

15-

Filed ... OCT 10 1920 ..., 191...

ROBERT B KRAUTER Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 9, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 12th 1920, to Oct 9th 1920, that I saw h-- alive on Oct 8 1920, and that death occurred, on the date stated above, at 5-40 A.M.

The CAUSE OF DEATH* was as follows:

... Pneumonia Croupous

... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... Senility

... (Duration) ... yrs. ... mos. ... ds.

(Signed) ... John H. Ould M. D.

10/9/20 191... (Address) 1543 N Gay St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 yrs. 8 mos. 22 ds. In the State 77 yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence 132 N Randall St

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill — DATE OF BURIAL, Oct ..., 1920

20-UNDERTAKER Jos B Cook — ADDRESS 1003 W Balto St

BE SURE TO READ carefully and answer all questions fully. Every item is important. See instructions on back of certificate.

047178 HEALTH DEPARTMENT—CITY OF BALTIMORE 047178

CERTIFICATE OF DEATH.

REGISTERED No. C 24174

1-PLACE OF DEATH

CITY OF BALTIMORE (No. B. & O. R. R. Yards Locust Point STR. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John George Hopf.

(Residence in Baltimore: No. 143 E. Randall St.

32 8 1
St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH, February 5th, 1888., 1.....
(Month) (Day) (Year)

7-AGE, 32 yrs. 8 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Car repairer.
(b) General nature of industry, business, or establishment in which employed (or employer)..... B. & O. R. R. Co.

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, George H. Hopf.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Barbara Stump.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick G. Hopf. (brother)

(Address) 1417 N. Bond St.

15- Filed OCT 10 1920, 191... ROBERT E KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 7th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion of the Brain.
Accidentally struck on side of head by a jack handle.
(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) .....
(Duration)..... yrs..... mos..... ds.

(Signed) Otto W. Reinhardt M. D.
(Coroner)

Oct. 9th. 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Carmel Cemetery	Oct. 11 1920
20-UNDERTAKER John F. Denny	ADDRESS 715 Light St

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

1047179 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047179

CERTIFICATE OF DEATH.

REGISTERED No. C 9

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 124 E. Barney St. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Marian Dunivin

(Residence in Baltimore: No. 124 E. Barney St. St.; 1 yrs., 7 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Single.

6-DATE OF BIRTH, February 23rd. 1919., 1
(Month) (Day) (Year)

7-AGE, 1 yrs. 7 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore. Md.

PARENTS.

10-NAME OF FATHER, Myrtie Dunivin.

11-BIRTHPLACE OF FATHER (State or Country), St Louis Mo.

12-MAIDEN NAME OF MOTHER Nettie O. Hall.

13-BIRTHPLACE OF MOTHER (State or Country), Mt. Airey Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Myrtie Dunivin. (father)

(Address) 124 E. Barney St.

15-

Filed OCT 10 1920, 191 ROBERT P KRAUTER Registrar.
Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 9th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diphtheria.

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Toxaemia.

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto Fehrmandt M. D.
(Coroner)

Oct. 9th, 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cemetery. DATE OF BURIAL, Oct. 10 1920

20-UNDERTAKER John H. Denny ADDRESS 715 Light St

N.B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047180 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047180

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5314 Denmore Av ST. 27 WARD)

2-FULL NAME Julia A. Watts

(a) RESIDENCE. No. 5314 Denmore Av ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Watts

6 DATE OF BIRTH (month, day, and year) Mar 8 1833

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... 000

(b) General nature of industry, business, or establishment in which employed (or employer) Home-wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md

PARENTS

10 NAME OF FATHER Henry Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant (Address) John A. Watts 5314 Denmore Ave

15 Filed OCT 10 1920 19... DOROTHY R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9th 1920

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1920, to Oct 8th, 1920, that I last saw h[illegible] alive on Oct 8th, 1920, and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) X yrs. 6 mos. 7 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At Residence

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) L. Frank Miller M. D.

10/9/20 (Address) Reisterstown Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dubbs Cemetery Glenburnie Md	Oct 11 1920
20 UNDERTAKER	ADDRESS
John H. Denny	715 Eutaw St

Spec.—6-9-19—H. P. Co.—1000 Pks.

D47181 HEALTH DEPARTMENT—CITY OF BALTIMORE D47181

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 241 S. 5th. ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Florence P. Tillette

(a) RESIDENCE. No. 241 S. 5th ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 19. 1895

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
25	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-work.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Anne Arundel Co. Md.

PARENTS

10 NAME OF FATHER: Wm. M. Tillette.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Camden Co. North Carolina.

12 MAIDEN NAME OF MOTHER: Florence M. Linthicum.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Anne Arundel Co.

14 Informant: Wm. M. Tillette.
(Address): 241 S. 5th St. City

15 Filed OCT 10 1920 ROBERT E. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 7 - 1920

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1920, to Oct 7 - 1920, that I last saw her alive on Oct. 7, 1920, and that death occurred, on the date stated above, at 7-9 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis. —

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary): Cardiac Trouble Chronic.

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Holland Apt.

Did an operation precede death? No. Date of None.

Was there an autopsy? No.

What test confirmed diagnosis? Through Exam.

(Signed) W. C. Tillette, M. D.

1921 (Address) 3508 Bank St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Church Cemetery

DATE OF BURIAL: Oct 11 1920

20 UNDERTAKER: John F. Denny

ADDRESS: 115 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Abbreviations may be used. Information is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47182 HEALTH DEPARTMENT—CITY OF BALTIMORE D47182

CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2337 Eastern ave. St.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha V. Rainer

(a) RESIDENCE. NO. 2337 Eastern ave. St.: 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph D. Rainer

6 DATE OF BIRTH (month, day, and year) Jan. 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Wimpsett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Joseph Rainer (Address) 2337 Eastern ave.

15 Filed OCT 10 1920 19 ROBERT E KRAUSER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6th 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9th, 1920, to Oct. 6, 1920, that I last saw h er alive on " 6, 1920, and that death occurred, on the date stated above, at 11 p m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. 1 mos. ds.

18 Where was disease contracted If not at place of death? At Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) C Krieg, M. D.

, 19 (Address) 4085 Park Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	10/11 1920

20 UNDERTAKER John A. Moran ADDRESS 3000 E. Balto.

CAUSE OF DEATH to be plainly stated. Each statement must be complete. See instructions on back of certificates. TION is very important.

1047183 HEALTH DEPARTMENT--CITY OF BALTIMORE 1047183

CERTIFICATE OF DEATH

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 818 W. Lexington St ST.: 18 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William S. Davidson

(Residence in Baltimore: No. 818 W. Lexington St.; 70 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, ~~MARRIED~~ ~~WIDOWED~~ OR DIVORCED. (Write the word): Single

6-DATE OF BIRTH: 1847 (Month), 1 (Day), (Year)

7-AGE: 73 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: no occupation
(b) General nature of industry, business, or establishment in which employed (or employer): no

9-BIRTHPLACE (State or country): Md.

PARENTS

10-NAME OF FATHER: Charles Davidson

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Hannah Foster

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nettie F. Foster

(Address) 1409 W. Lafayette Ave

15- OCT 10 1920 ROBERT F. KRAUTER

Filed ....., 191 .... Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct. (Month) 9 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 25" 1920 to Oct 9" 1920 that I saw h~~im~~ alive on Oct. 8" 1920 and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Dysentery

(Duration) yrs. mos. 14 ds

Contributory (SECONDARY) Weak heart & old age

(Duration) yrs. mos. ds.

(Signed) Wm B Rider M. D.

Oct 9" 1920 (Address) 867 Harlem Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 11, 1920

20-UNDERTAKER: George J Smith

ADDRESS: 1000 Fayette W

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

047184 HEALTH DEPARTMENT—CITY OF BALTIMORE 047184

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2227 N. Bruce ST.: 12th WARD) 120

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah Chaney

(Residence in Baltimore: No. 2227 N. Bruce St.: yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	married

6-DATE OF BIRTH, Unknown, 18..70
(Month) (Day) (Year)

7-AGE, 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 13

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Geo. Burley

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Chaney

(Address) 2227 N. Bruce

15- Filed OCT 10 1920, 191 ROBERT B KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 7, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Oct 8, 1920 (Address) 2227 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Calvary	Oct. 10, 1920
JAMES H. DENNIS	
20-UNDERTAKER	ADDRESS
1303 PRESTMAN ST.	

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047185 HEALTH DEPARTMENT—CITY OF BALTIMORE 047185

CERTIFICATE OF DEATH. 25 X 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. William Black

(a) RESIDENCE. No. Ellicott City, Md WARD Ellicott City

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. H. Black

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
22	2	Do not Know	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Undertaker 086

(b) General nature of industry, business, or establishment in which employed (or employer) Undertaker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Black

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Cora Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Wm. Black

(Address) Ellicott City Md

15 Filed OCT 11 1920 ROBERT F. KELLER Registrar

Burial Permit Oct 12

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1920, to Oct 10, 1920 that I last saw him alive on Oct 10, 1920 and that death occurred, on the date stated above, at 9:45 a m.

The CAUSE OF DEATH* was as follows: Diabetes Mellitus

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Parenchymatous Nephritis, Uraemia

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & physical findings

(Signed) Damon F. Alloga, M. D.

, 19 (Address) 3326 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Johns Cem. Howard Co.	Oct. 12 1920
20 UNDERTAKER	ADDRESS
Easton Sons	Ellicott City

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 47186 HEALTH DEPARTMENT—CITY OF BALTIMORE D 47186

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1719 Barclay ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Parsons

(Residence in Baltimore: No. 1719 Barclay St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Oct (Month) 8 (Day), 1920. (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, 10 hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, William M. Parsons

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Ellen Seamond

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Powers

(Address) 1719 Barclay St

15- OCT 11 1920 ROBERT B KRAUTER

Filed....., 191.... BUREAU VITAL STATISTICS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 9 (Day), 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1920, to Oct 9 1920, that I saw h.. alive on Oct 8 1920, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Jacob Frahes M. D.

Oct 10 1920 (Address) 1823 N. Wash Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem.

DATE OF BURIAL, Oct. 11th., 1920.

20-UNDERTAKER George J. Puth

ADDRESS 1735 Harford Ave

Please print plainly in ink. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

947187 × 79 947187

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles Gore

(a) RESIDENCE. NO. 714 W. Fayette St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State) Illinois

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 (Single), Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37 yrs	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Jockey

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ashley Ill.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Wm E Tyrrell

(Address): 719 W Fayette St.

15 Filed, OCT 11 1920 ROBERT B [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 9 1920

17 I HEREBY CERTIFY, That I attended deceased from October 8, 1920, to October 9, 1920, that I last saw h.im alive on October 9, 1920, and that death occurred, on the date stated above, at 1.00 a.m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Bronchitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. G. Geyer, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashley Illinois

DATE OF BURIAL: Oct 11 1920

20 UNDERTAKER: William Cook

ADDRESS: Nor E Nat

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

1047188

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047188

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Maryland General Hosp. ST.) 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Clarke Keyser.

(a) RESIDENCE. No. 1820 St Paul St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, ~~divorced~~
~~HUSBAND~~ WIFE of Richard Fuller Keyser

6 DATE OF BIRTH (month, day, and year) 1859-10-5

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Christopher Raborg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Virginia C Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Robert Levering Keyser
(Address): 1826 St Paul St.

15 Filed OCT 11 1920 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9th 1920

17

I HEREBY CERTIFY, That I attended deceased from October 2 1920 to October 9 1920, that I last saw her alive on Oct. 9 1920, and that death occurred, on the date stated above, at 5:35 P m.

The CAUSE OF DEATH* was as follows:

Uterine fibromata over

(duration) ... yrs. 16 mos. ... ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? at Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Fry Kumpakis, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
GREEN MOUNT CEMETERY CO	Oct 12 1920
20 UNDERTAKER: HENRY W. JENKINS & SONS CO	ADDRESS: MC CULLOH & ORCHARD STS.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

2047189 HEALTH DEPARTMENT—CITY OF BALTIMORE 2047189

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2745 N. Calvert ST.: W WARD) REGISTERED NO. 40

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Batchelor White

(a) RESIDENCE. No. 2745 N. Calvert ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced (or) WIFE of Charles White

6 DATE OF BIRTH (month, day, and year) August 3-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady. D37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jacob Batchelor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles White (Address) 2745 N. Calvert St

15 Filed OCT 11 1920 ROBERT F. KRAUTER (Registrar) Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 8 1920, to Oct 8 1920, that I last saw h alive on Oct. 7 1920, and that death occurred, on the date stated above, at 11 40 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Oesophagus)

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Metastasis to pleura,

Myocarditis (duration) — yrs. — mos. 17 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Radioscopic.

(Signed) Louis P. Hamburger, M. D.

Oct 10, 1920 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Oct 11 1920

20 UNDERTAKER HENRY W. JENKINS & SONS CO. ADDRESS MC CULLOH & ORCHARD STS.

Spec.—8-24-14—M. & T.—2000 Bks.

D 47190

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47190

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.; 24 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary K. D. Feeney

(Residence in Baltimore: No. 1140 Battery Ave St.; 14 yrs., 9 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Dec 22 (Month) (Day), 1905 (Year)

7-AGE, 14 yrs. 9 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Typist 086
(b) General nature of industry, business, or establishment in which employed (or employer): Atlantic Ref Co.

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Jos Feeney

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary Buskman

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Feeney

(Address) 1140 Battery Ave

15-

Filed OCT 11 1920 191.... ROBERT B KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 7th (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 4 1920, to Oct 7th 1920, that I saw her alive on Oct 7th 1920, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ....yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Suppurative Appendicitis

(Duration) ....yrs. mos. 6 ds.

(Signed) Mary B Coll M. D.

Oct 7/20, 191... (Address) 1203 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. mos. 3 ds. In the State 14 yrs. 9 mos. 15 ds.

Where was disease contracted, if not at place of death? 1140 Battery Ave

Former or usual residence "

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross Cem	Oct 11..., 1920
20-UNDERTAKER	ADDRESS
E + B Hartle	115 E North Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47192

HEALTH DEPARTMENT—CITY OF BALTIMORE

170 D47192

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 N Eden ST.: 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Armenius Tyler

(a) RESIDENCE. NO. 11 N Eden ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. ~ mos. ~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept 20 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 000

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Md

PARENTS

10 NAME OF FATHER Solomon Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary C. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Elmer J. Jones (Address) Lake Building

15 Filed OCT 11 1920 ROBERT P. LAMOTTE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1920, to Oct 8 1920, that I last saw h~ alive on Oct 8 1920, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Ch Nephritis — Cystitis —

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pulm. Congestion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles F Blake, M. D.

Oct 10, 1920 (Address) 20 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 12 1920
20 UNDERTAKER	ADDRESS
John F Denny	715 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE. TION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

Bourne

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047192 1047192

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2300 Harlem Ave ST.; 16 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. L.W. Bourne

(Residence in Baltimore: No. 2301 Harlem Ave St.; 60 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, March 5th, 1844
(Month) (Day) (Year)

7-AGE, 77 yrs. 7 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Agent
(b) General nature of industry, business, or establishment in which employed (or employer)..... Milk-Hillsdale Farm Co

9-BIRTHPLACE, (State or Country), Calvert Co Md.

PARENTS.

10-NAME OF FATHER, James J Bourne

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sara L. Weems.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Alice L Bourne

(Address) 2301 Harlem Ave

15- Filed OCT 11 1920, 191... ROBERT F KRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 10 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 10. 1920, to Oct 10 1920, that I saw h[illegible] alive on Oct, 10 1920, and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Duration) ..... yrs. ..... mos. Less than 1 day.

CONTRIBUTORY (Secondary) Angina

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. H. Phillips M. D.

10-10, 1920 (Address) 2300 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery | DATE OF BURIAL, Oct 12, 1920

20-UNDERTAKER Bertram Gore | ADDRESS 1123 N. Lafayette Ave

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

947193 HEALTH DEPARTMENT—CITY OF BALTIMORE 947193

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 834 W. Baltimore St.; 18 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Fischer

(Residence in Baltimore: No. 834 W. Balto St.; St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, March (Month) 9 (Day), 1877 (Year)

7-AGE, 43 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bar Tender
(b) General nature of industry, business, or establishment in which employed (or employer): 044

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Hamel

(Address) 834 W. Balto St

15- ROBERT B KRAUTER

Filed OCT 11 1920, 191 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 9 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, or autopsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart — a few months (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know (Duration) yrs. mos. ds.

(Signed) H. H. Forrest M. D. (Coroner.)

Oct 11, 1920 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
London Park	Oct 12 1920

20-UNDERTAKER	ADDRESS
Mrs Mrs John W. Siegel	801 W Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 47194

1042 D 47194

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2438 Fleet ST.: 1 st- WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ADAM STRICHASZ,

(a) RESIDENCE. NO. 2438 Fleet ST. 1 st- WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male,	White,	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 18-1920,

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant, 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.,

PARENTS

10 NAME OF FATHER Joseph Strichasz,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Antonia Mach,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

10/9/20

14 Informant Mrs. Antonia Strichasz, (Mother)
(Address) # 2438 Fleet Street.

15 Filed OCT 11 1920 19 ROBERT P. FOUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 6 1920. Oct 9 1920.

that I last saw him alive on Oct 9 1920.

and that death occurred, on the date stated above, at 4.30 P- m.

The CAUSE OF DEATH* was as follows:

Entro Colitis

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilbur H. Knauer M. D.

(Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	Oct 11" 1920
20 UNDERTAKER W. F. Sadowski.	ADDRESS 405 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47195

D 47195

CERTIFICATE OF DEATH.

80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 N. Milton Ave STR. 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma V. Price

(a) RESIDENCE. No. 32 N. Milton Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Peter J. Price

6 DATE OF BIRTH (month, day, and year) June 9-59

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Frank Reinig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Peter J. Price

(Address) 32 N. Milton Ave

15 Filed OCT 11 1920 19 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1920, to Oct 10, 1920, that I last saw h[illegible] alive on Oct 9, 1920 and that death occurred, on the date stated above, at 5-15 A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene L. Pessagno, M. D.

Oct 10, 1920 (Address) 2314 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct. 13 1920
20 UNDERTAKER Philip Henrig	ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47196

CERTIFICATE OF DEATH.

50 D47196

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2610 Jefferson ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Miller

(a) RESIDENCE. NO. 2610 Jefferson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. — mos. — ds. How long in U. S., if of foreign birth? 38 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: Paul Miller

6 DATE OF BIRTH (month, day, and year): Aug 30-53

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Harry Neutze (Address) 2610 Jefferson

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct-2, 1920, to Oct 9, 1920, that I last saw her alive on Oct-9, 1920, and that death occurred, on the date stated above, at 11 55 A m.

The CAUSE OF DEATH* was as follows:

Diabetis and Hemiplegia.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Coma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary Analysis

(Signed) Adolph C. Eisenbarg, M. D.

Oct 10, 1920 (Address) 2201-03 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Oct 12 1920

20 UNDERTAKER: Philip Hennig — ADDRESS: 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU-TION is very important. See instructions on back of certificates.

Burial Permit Issued

Spec.—6-9-13—H. P. Co.—1000 Bks.

D47197

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47197

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1933 E. North Ave ST. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeline Marie Denton

(a) RESIDENCE. No. 1933 E. North Ave ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Harvey W. Denton

6 DATE OF BIRTH (month, day, and year) Sept. 20-90

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	—	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Frank J. McGinnis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary J. Curran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Harvey W. Denton
(Address) 1933 E. North Ave

15 Filed OCT 11 1920 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9th 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 1920 to Oct 9th 1920

that I last saw h... alive on Oct 6th 1920

and that death occurred, on the date stated above, at 1 30 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. O. Stuart M. D.

(Address) 1501 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Oct. 12 1920
20 UNDERTAKER	ADDRESS
Philip Herrig	2016 Adams St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MEDICO-PATHOLOGICAL CONDITION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D47198

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47198

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 W. Franklin ST.; 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Brown

(Residence in Baltimore: No. 1619 W. Franklin St.: all life yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Not known ....., 1872
(Month) (Day) (Year)

7-AGE, 48 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... General house work

9-BIRTHPLACE, (State or Country), Balto. City Md.

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Robinson

(Address) 1619 W. Franklin

15-

Filed....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 6, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 27 1920, to Oct 6 - 1920, that I saw h.e alive on Oct 6 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

about one year
(Duration) yrs. mos. ds.

CONTRIBUTORY.....
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. L. McLenahan M. D.

Oct. 7, 1920 (Address) 906 N. Stricker St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn	Oct. 11, 1920
20-UNDERTAKER	ADDRESS
Edw. Ringgold	1463 Carey St

Property of Baltimore City Department of Public Health. Please return in plain envelope as soon as may be convenient. Information on this certificate important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D47199

1920 D47199

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 314 N. Biddle St.: 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grant Worthy

(a) RESIDENCE. No. 314 Biddle St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Worthy

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steveder

(b) General nature of industry, business, or establishment in which employed (or employer) 074

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newberry S C

PARENTS

10 NAME OF FATHER Dead Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dead Unknown

12 MAIDEN NAME OF MOTHER Mary Jackson

13 BIRTHPLACE OF MOTHER (city or town) Atlanta Ga (State or country)

14 Informant Lemil Easton (Address) 916 Penn ave

15 Filed OCT 11 1920, 19 ROBERT E LAZARUS Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9th 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 27, 1920, to Oct 9th, 1920, that I last saw him alive on Oct 8th, 1920, and that death occurred, on the date stated above, at 2:15 P m.

The CAUSE OF DEATH* was as follows:

Hypostatic Congestion of the Lungs secondary to mitral Regurgitation

(duration) yrs. mos. 29 ds.

CONTRIBUTORY (Secondary) Nephritis Chronic

(duration) 2 days — mos. 29 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) L. B. Evans, M. D.

19 (Address) Greene & Franklin Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Oct 11 1920

20 UNDERTAKER Lemil Easton ADDRESS 916 Penn ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47200

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47200

38

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie Hopkins

(a) RESIDENCE. No. 729 Franklin St. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Unknown M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 870

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed OCT 11 1920 19 ..... Registrar

..... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1920, to October 8, 1920, that I last saw her alive on October 8, 1920, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows: Salpingitis

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Post operative Int. obstruction

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? Yes Date of Oct. 2, 1920

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) Chas. B. Marshall, M. D.

10/8/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M. A. Cubin Co	Oct 12 1920
20 UNDERTAKER	ADDRESS 916
Daniel Easter	Penn Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47201

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47201

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital St.: 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Backhert

(a) RESIDENCE. No. 339 S. 3rd St., St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brewery-man 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed OCT 11 1920 ROBERT B BRAUER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 8, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1920 to October 8, 1920.
that I last saw him alive on October 8, 1920.
and that death occurred, on the date stated above, at 2:00 P.M.
The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed) B Herman. M. D.

10/8/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Oct 12 1920
20 UNDERTAKER	ADDRESS
Lilly Ed Zeiler	403 S. Mo[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 47202

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 D 47202

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 2922 Harford ave ST.: 9 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William Thomas Dietsch

(Residence in Baltimore: No. 2922 Harford ave St.: 59 yrs. 8 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Jan 20 1861 (Month) (Day), 1 (Year)

7 AGE: 59 yrs. 8 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Hardware Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Adam Dietsch

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Logan

13 BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Brother J. L. Dietsch

(Address) 205 Homestead St

15 Filed OCT 11 1920, 191 ROBERT E KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 10 1920 (Month) (Day), 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from about 14 Mo., 191.., to. Oct 10 1920.
that I saw h.. alive on Oct 7 .19..
and that death occurred, on the date stated above, at 2104 m.
The CAUSE OF DEATH* was as follows:

Sarcoma of Liver

about 14 Mo (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) —

(Duration) — yrs. — mos. — ds.

(Signed) H. G Ornduff M. D.

Oct 12, 1920. (Address) 634 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Biddisons Family Cemetery
DATE OF BURIAL: October 12th 1920

20 UNDERTAKER: George Schilling & Sons
ADDRESS: 1126 E Monument St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-3-19—H. P. Co.—1000 Bks.

Rever

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D47203

CERTIFICATE OF DEATH.

12157 D47203

1-PLACE OF DEATH Bidle Pediatric Hosp.

REGISTERED NO.

CITY OF BALTIMORE: (No. 2724 N. Chas St.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Benj. Rever Jr

(a) RESIDENCE. NO. 7 Alleston Ave ST. Hamilton Md WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 6 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or mln.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country) 2724 N. Chas St

PARENTS

10 NAME OF FATHER Wm Benj. Rever

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Orangeville Md

12 MAIDEN NAME OF MOTHER Amy Blanche Wright

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Wm Benjamin Rever
(Address) 7 Alleston Ave

15 Filed OCT 11 1920, 19 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1920

17

I HEREBY CERTIFY, That I attended deceased from Birth, 19, to Oct 9, 1920, that I last saw him alive on Oct 9/20 - 11 PM, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

about

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. H. Potter M. D.

, 19 (Address) 508 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Oct 11th 1920
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47204

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D47204

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 Lorraine Ave ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy A. Claston

(a) RESIDENCE. NO. 420 Lorraine ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of William H. Claston

6 DATE OF BIRTH (month, day, and year) June 16 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in whieh employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co Md

PARENTS

10 NAME OF FATHER Joseph Croxton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Rawl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Wm J. Healy
(Address) 420 Lorraine

15 Filed OCT 11 1920 19.. DONALD B. KRAUTER Registrar

Burial Permit 01671

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to Oct 10, 1920, that I last saw h.. alive on Oct 9, 1920, and that death occurred, on the date stated above, at 8 40 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Moby Hoag, M. D.

19/11/1920 (Address) 729 Columbia ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laneytown Maryland	Oct 13 1920
20 UNDERTAKER	ADDRESS
William Cook	502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MEDICAL TION is very important. See instructions on back of certificates.

Dr Hoag 729 Columbia Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

047205 HEALTH DEPARTMENT—CITY OF BALTIMORE 047205

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Taylor & Valley Sts. St.: 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Fallon.

(a) RESIDENCE. No. Little Sisters of the Poor. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of: of Luke Fallon.

6 DATE OF BIRTH (month, day, and year): July 31, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 400

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore.

PARENTS

10 NAME OF FATHER: Simon Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Ann Mulhall.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Sister Florence

(Address): Taylor & Valley Sts.

15 Filed OCT 11 1920 ROBERT B. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 10 1920

17 I HEREBY CERTIFY, That I attended deceased from No record, 19..., to ..., 19...

that I last saw her alive on Oct 9, 1920.

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsion

24 hrs (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

Oct 10 1920 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct 12 1920

20 UNDERTAKER: John B Spence ADDRESS: 1320 E. Lombard St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-47206 HEALTH DEPARTMENT—CITY OF BALTIMORE D47206

CERTIFICATE OF DEATH. X 115

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.. 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Temple Smith

(a) RESIDENCE. No. Greensboro, Md ST., WARD. Jamestown

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Christian Smith

6 DATE OF BIRTH (month, day, and year) Aug — 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Member Co. "D" 1st Regt Md Nat Guard

(b) General nature of industry, business, or eslabishment in which employed (or employer) J F P. Roe Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Charles W Small

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware.

12 MAIDEN NAME OF MOTHER Rachael Cannel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant George E. Saulsbury (Address) 2730 N. Charles St

15 Filed OCT 11 1920 16 ROBERT E. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1920

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1920, to Oct 11, 1920, that I last saw him alive on Oct 11, 1920, and that death occurred, on the date stated above, at 3.55 A m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Post Operative Intestinal Obstruction (duration) yrs. mos. 3 Wks.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Yes Date of Oct 1. 1920 Oct 11. 1920

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) John W Hurley M. D.

10/11 1920 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greensboro. Md	Oct 1920
20 UNDERTAKER Jos B Cook	ADDRESS 103 W Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

047207

HEALTH DEPARTMENT—CITY OF BALTIMORE

047207

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 E Lee St. 22 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda Carter

(a) RESIDENCE. No. 5 E Lee St., ... Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 23 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Ben- Shorts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Matilda Caldwell

(Address) 5 E Lee St

15 Filed OCT 11 1920 19.. ROBERT P. BEAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1920, to Oct 9, 1920, that I last saw h[er] alive on Oct 9, 1920, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) ... yrs. 7 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urinary

(Signed) H. S. McCard M. D.

, 19 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn St	Oct 12 1920
20 UNDERTAKER	ADDRESS
L. E. Brown & Son	118 W Mont

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D47208 HEALTH DEPARTMENT—CITY OF BALTIMORE D47208

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3401 Park Heights Ave St.) 15 WARD) 79 REGISTERED No. C..

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Condit

(Residence in Baltimore: No. 3401 Park Heights Ave St.: 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH. May (Month) 7 (Day), 1847 (Year)

7-AGE. 76 yrs. 5 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None 000.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Washington Co. Pa

PARENTS.

10-NAME OF FATHER. Isaac Jennings

11-BIRTHPLACE OF FATHER (State or Country). Pa

12-MAIDEN NAME OF MOTHER. Susanna Phelps

13-BIRTHPLACE OF MOTHER (State or Country). Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma May Miller

(Address) 3401 Park Heights Ave

15-

Filed ....., 191... Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct 9th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D.
(Coroner.)

Oct 12 1920 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park Cem.	Oct 12 1920
20-UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W. North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47209

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47209

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. City Hospital, Bay View WARD 21)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Leightheart

(a) RESIDENCE. No. 915 S. Paca ST. 21 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Records (Address) City Hospital, Bay View

15 Filed OCT 11 1920 19 ROBERT R KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 6, 1920, to Oct 9, 1920, that I last saw h ... alive on Oct 9, 1920, and that death occurred, on the date stated above, at 2 45 P m.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Lung abscess

(duration) yrs. mos. 8 ds(?)

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) B. Herrman M. D.

Oct. 10 1920 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 12 1920
20 UNDERTAKER	ADDRESS
James Dignan & Son	1011 S Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47210 HEALTH DEPARTMENT—CITY OF BALTIMORE D47210

CERTIFICATE OF DEATH. 151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1436 Battery ST. 24 WARD)

2-FULL NAME Marie Kuhlman

(a) RESIDENCE. NO. 1436 Battery Av ST. 24 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 25 20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(e) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Conrad Kuhlman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret Friedmiller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Conrad Kuhlman (Address) 1436 Battery Av

15 Filed OCT 11 1920 19 ROBERT E. LAMBERT Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1920, to Oct 10 1920, that I last saw h[illegible] alive on Oct 10 1920, and that death occurred, on the date stated above, at 1.A m.

The CAUSE OF DEATH* was as follows:

Pneumonia due to Cardiac Asthenia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Intrition

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

(Address) 835 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Oct. 11. 1920

20 UNDERTAKER E. J. Fanning & Son

ADDRESS 1460 Battery Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 47211

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 47211

CERTIFICATE OF DEATH.

1-PLACE OF DEATH unknown

CITY OF BALTIMORE: (No. 837 Hollins St. St.; 19 WARD) 104

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Patterson

(Residence in Baltimore: No. 837 Hollins St. St.: ... yrs. 3 mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.)

6-DATE OF BIRTH, unknown (Month) ..., 1 (Day) ... (Year)

7-AGE, ... yrs. 3 mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... None
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Maryland Baltimore

PARENTS.

10-NAME OF FATHER, O'Donnell

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Murphy

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. B. Mullikin

(Address) 837 Hollins St.

15-

Filed ... 1920 Robert P. Harrison, Registrar.

OCT 11 1920

Burial Permit Clerk.

17555

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 9 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Aug 31 1920, to Oct 9 1920, that I saw him alive on Oct 8 1920, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Premature birth

... (Duration) ... yrs. 5 mos. ... ds.

CONTRIBUTORY (Secondary) Bronchitis & Pneumonia (Under 1 yr) 4

... (Duration) ... yrs. ... mos. ... ds.

(Signed) Johnson Baldwin M. D.

Oct 9, 1920 (Address) 501 Prof. Bldg.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. 6 mos. ... ds. Is the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL — DATE OF BURIAL, OCT. 9 - 1920

20-UNDERTAKER Commissioner Health. — ADDRESS

Per. Wm E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47212 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47212

CERTIFICATE OF DEATH. H1

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 W. Fayette ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kate Lowenbach.

(Residence in Baltimore: No. 1516 W. Fayette — St.; 80 yrs., — mos. — ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, May 26, 1841. (Month) (Day) (Year)

7-AGE, 79 yrs. 6 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Samuel Coffon

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Catherine Myers.

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sallie E. Lowenbach

(Address) 1516 W. Fayette St.

15-

Filed OCT 11 1920, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 10, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 3 1920, to Oct 10 1920, that I saw her alive on Oct 10 1920, and that death occurred, on the date stated above, at 1.40 P.M.

The CAUSE OF DEATH* was as follows:

.....

.....Carcinoma of Uterus - also rectum)

..... (Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary).....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) M Bowman Kooch M. D.

Oct. 11, 1920. (Address) 626 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Lorraine. DATE OF BURIAL, Oct 12, 1920.

20-UNDERTAKER George J. Smith ADDRESS 1500 W Fayette St

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.47213

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47213

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2859 Wallbrook Ave ST.: 15 WARD) 120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Kendig Bowersox

(a) RESIDENCE. No. 2859 Wallbrook ave ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Bowersox

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none D37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Lancaster Pa.

PARENTS

10 NAME OF FATHER Francis Kendig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Annie Kendig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs. Lester Wallace

(Address) 2839 Wallbrook ave.

15 Filed ..... 19 .....

Registrar

OCT 12 1920 Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1920, to Oct. 10, 1920, that I last saw h[illegible] alive on Oct. 9, 1920, and that death occurred, on the date stated above, at 2.45 A m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular lesions of heart

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Leonard E. Beach, M. D.

Oct. 19 20 (Address) 323 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Oct 12 1920
20 UNDERTAKER George J. Smith	ADDRESS 2066 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47214 HEALTH DEPARTMENT—CITY OF BALTIMORE D47214

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2034 Robb ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Kraus

(a) RESIDENCE. NO. 2034 Robb ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of) the late Wilhelmina Kraus

6 DATE OF BIRTH (month, day, and year) Jan. 6 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mr Peter Schafer

(Address) 2034 Robb St

15 Filed OCT 11 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 10 1920

17 I HEREBY CERTIFY, That I attended deceased from September-30, 1920, to October-10, 1920, that I last saw him alive on October-10, 1920, and that death occurred, on the date stated above, at 8 12 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis - Bronchitis - Cystitis arteriosclerosis - Cerebral Hemorrhage - Hypostatic Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Senility

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William F. Schwartz M. D.

Oct 11, 1920 (Address) 1200 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct. 13 1920
20 UNDERTAKER	ADDRESS
Henry Horck Son	1301 E Eager

INFORMATION should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47215 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47215

CERTIFICATE OF DEATH.

8 72

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1111 N Milton Ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Snyder

(a) RESIDENCE. NO. 1111 N Milton ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 10 mos. 5 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 5 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	14	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Henry Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary K Farmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

11 Informant Mary K. Snyder
(Address) 1111 N Milton Ave

15 Filed Oct 11 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1920, to Oct 10, 1920, that I last saw her alive on Oct 9, 1920, and that death occurred, on the date stated above, at 2 20 p. m.

The CAUSE OF DEATH* was as follows:

Mineral Exhaustion (duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) W. E. Fletcher M. D.

Oct. 11 1920 (Address) 1301 N Bat Pave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 13 1920
20 UNDERTAKER John Collins	ADDRESS 2018 Pulaski

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 11 1920

Spec.—6-9-19—H. P. Co.—1000 Bka.

D.47216 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47216

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 544½ N. Gay ST.; 5-50 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Steinberger

(a) RESIDENCE. No. 544½ N. Gay ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: WHITE | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5 1859

7 AGE: 61 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Marion Steinberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Esther Landauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Joseph Steinberger 1638 Light St

15 Filed OCT 11 1920 16 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1919, to Oct 10, 1920, that I last saw her alive on Oct 9, 1920, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mel.

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Urine Test

What test confirmed diagnosis?

(Signed) A. G. Slade, M. D.

19 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Butler Hebrew Cem. | DATE OF BURIAL: Oct. 12 1920

20 UNDERTAKER: J. Abrams & Son | ADDRESS: 1611 Madison Ave

mation should be carefully supplied. AGE should be stated
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

D. 47217 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 47217

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3603 Greenmount Ave. WARD) 79

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary F. Baden

(Residence in Baltimore: No. 3603 Greenmount Ave. S. 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, white. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct. (Month) 31 (Day), 1849 (Year)

7-AGE, 70 yrs. 11 mos. 10 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Harford Co. Md.

PARENTS.

10-NAME OF FATHER, Joseph Gorsuch

11-BIRTHPLACE OF FATHER (State or Country), Harford Co. Md

12-MAIDEN NAME OF MOTHER Ruth A. Russell

13-BIRTHPLACE OF MOTHER (State or Country), Harford Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles R. Bowen

(Address) Towson, Md.

15- Robert P. Harrison,

Filed OCT 11 1920, 191.... Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 10 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Bailey M. D.
(Coroner.)

10-11-20 (Address) Towson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Prospect Hill (Towson) | DATE OF BURIAL, Oct 12, 1920

20-UNDERTAKER Horace Burgee Son | ADDRESS 363 Fallsroad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.47218 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47218

CERTIFICATE OF DEATH.

175-004

1 PLACE OF DEATH — CITY OF BALTIMORE (No. Mercy Hospital St.: 6 Ward) — REGISTERED No. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Norman Grosner.

(Residence in Baltimore: No. 2818 E Baltimore St. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, July (Month) 20 (Day), 1906 (Year)

7-AGE, 14 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer): Gen Mdse

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frederick Grosner

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Agnes Cassilly

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. Frederick Grosner (Father)

(Address) 2818 E Baltimore St.

15- Robert P. Harrison,

Filed OCT 11 1920, 191.... Registrar.

Burial Permit Cle

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 8 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
Auto Car Accident

(Duration) hrs. mos. ds.

CONTRIBUTORY (Secondary) Shock.

(Duration) yrs. mos. ds.

(Signed) Geo. Lotton Blake M. D.
(Coroner)

10/11/20, 191... (Address) 1436 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cemetery	Oct 12, 1920

20-UNDERTAKER H E Hughes ADDRESS 17 S Broadway

N. B.—Every item of information should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1047219 HEALTH DEPARTMENT--CITY OF BALTIMORE 1047219

CERTIFICATE OF DEATH

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Main & Market St. 25 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James I Lane

(Residence in Baltimore: No. Main & Market St.: 4 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	Colored	Married

6-DATE OF BIRTH unknown, 1850 (Month) (Day) (Year)

7-AGE 70 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Minister
(b) General nature of industry, business, or establishment in which employed (or employer): 018

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: unknown

11-BIRTHPLACE OF FATHER (State or country): unknown

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (State or country): unknown

14-I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Lane

(Address) Westminster Md

15. Filed OCT 12 1920 191 ROBERT B KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Oct (Month) 10 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1920, to Oct 10 1920

that I saw him alive on Oct 10, 1920

and that death occurred, on the date stated above, at 12-20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 2 mos. ds

Contributory (SECONDARY) Uremia

(Duration) yrs. mos. 1 ds.

(Signed) H. Luckieffen M. D.

Oct 10, 1920 (Address) Mount Airy Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: U. S. National Cemetery

DATE OF BURIAL: Oct 13th 1920

20-UNDERTAKER: Felix B Rye

ADDRESS: 102 E. Madison St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47220

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47220

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 245 S. Ellwood ave ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Ward

(a) RESIDENCE. NO. 245 S. Ellwood ave 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 3 12 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Elizabeth Schuster

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Lee Ward

(Address) 245 S. Ellwood ave

15 Filed OCT 12 1920 19.. ROBERT E. CARTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1920

17

I HEREBY CERTIFY, That I attended deceased from 2 Oct 1920 to 9th Oct 1920 that I last saw him alive on 9 Oct 1920, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic endocarditis

(duration) 12 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) 301 S Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	10/12 1920
20 UNDERTAKER: J. J. Moran	ADDRESS 300 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1947221 HEALTH DEPARTMENT—CITY OF BALTIMORE 1947221

CERTIFICATE OF DEATH. 7 41V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 N. Washington St.; 7 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William S. Barton

(Residence in Baltimore: No. 827 N. Washington St.; 58 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, Feb 24, 1862
(Month) (Day) (Year)

7-AGE, 58 yrs. 7 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Hat finisher
(b) General nature of industry, business, or establishment in which employed (or employer): 886

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph Barton

11-BIRTHPLACE OF FATHER (State or Country), Frederick Md.

12-MAIDEN NAME OF MOTHER Margaret Cordwell

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Leifield

(Address) 827 N. Washington St

15- OCT 12 1920 ROBERT E LEAUTER

Filed....., 191.. BURIAL PERMIT (Registrar.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 10, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 23 1920, to Oct 10 1920, that I saw h[illegible] alive on Oct 10 1920, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Descending Colon

(Duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY (Secondary) General Metastasis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John D Fell M. D.

Oct 11, 1920. (Address) 9 E Mount St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Oct 13, 1920

20-UNDERTAKER Frank A. Fink ADDRESS 918 N. Gay St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D47222 HEALTH DEPARTMENT—CITY OF BALTIMORE D47222

Francis H. McAlister

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 Wyndham Road ST.; 27 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis H. McAlister

(Residence in Baltimore: No. 520 Windham Road St.: 42 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov 7, 1873.
(Month) (Day) (Year)

7-AGE, 46 yrs. 11 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Optician
(b) General nature of Industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Phila. Penna

PARENTS.

10-NAME OF FATHER, Wm J. McAlister

11-BIRTHPLACE OF FATHER (State or Country) Phila. Penna

12-MAIDEN NAME OF MOTHER Anne Mitchell

13-BIRTHPLACE OF MOTHER (State or Country). Phila. Penn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Wendell McAlister

(Address) 520 Windham Road

15-

Filed OCT 12 1920, 191.... ROBERT E KRAUTH
Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 9, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1920, to Oct 9 1920, that I saw h alive on Oct 9 1920, and that death occurred, on the date stated above, at 10.10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage. Apoplexy.

(Duration) 2 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Valvular disease

(Duration) 2 yrs. mos. ds.

(Signed) C. B. Nourse M. D.

Oct 9 1920, (Address) 3543 Chestnut Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Philadelphia Pa DATE OF BURIAL, Oct 12 1920

20-UNDERTAKER John Ostenfeld & Bro ADDRESS 1201 N. Broad

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D47223 HEALTH DEPARTMENT--CITY OF BALTIMORE D47223

CERTIFICATE OF DEATH

43

1 PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE (No. Mt Royal Apartments. St.: 11 WARD) (If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Elizabeth Barrett Cummings.

(Residence in Baltimore: No. Mt Royal Ave & Calvert Sts. St.: 7 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married.

6 DATE OF BIRTH: April 5th, 1886 (Month) (Day) (Year)

7 AGE: 34 yrs. 6 mos. 5 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): New York City.

PARENTS

10 NAME OF FATHER: Joseph H. Benjamin.

11 BIRTHPLACE OF FATHER (State or country): Pennsylvania.

12 MAIDEN NAME OF MOTHER: Abby Sabin.

13 BIRTHPLACE OF MOTHER (State or country): Mass.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph A Cummings.

(Address) Mt Royal Apts.

15 OCT 12 1920 ROBERT B KRAUTER
Filed ....., 191 ..... Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. 11th, 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1920. to. Oct 11th 1920, that I saw her alive on Oct 11. 1920, and that death occurred on the date stated above, at 2.30 A m.
The CAUSE OF DEATH* was as follows:

Cancer of breast. Metastasis to bone, liver, spleen -

(Duration) 1 yrs. 6 mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), Harry D. McCarty M. D.

Oct 11, 1920 (Address) 31 W. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Fidorite Pa. DATE OF BURIAL: Oct 12, 1920

20 UNDERTAKER: John Mitchell ADDRESS: 801 W. Fayette St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S [illegible] state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D47224 HEALTH DEPARTMENT—CITY OF BALTIMORE D47224

150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 598 N. Pulaski St.: 17 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Cockey

(Residence in Baltimore: No. 598 N. Pulaski St.; yrs., mos. 13d.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, October 9, 1920
(Month) (Day) (Year)

7-AGE, ...yrs....mos....7....ds.

If LESS than 1 day, 13 hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... (Infant)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Clarence Cockey

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Isabell Howard

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence Cockey

(Address) 598 N. Pulaski St

15-

Filed OCT 12 1920, 191.... ROBERT B KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH October 10, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest~~ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~jury~~ (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale

(Duration) ....yrs....mos. 1 ....ds.

CONTRIBUTORY (Secondary) ~~J. D. Hennessy~~

(Duration) ....yrs....mos....ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)

October 10, 1920. (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Oct. 12, 1920

20-UNDERTAKER David Hunsley — ADDRESS 578 N Bradford

Spec.—8-24-14—M. & T.—2000 Bks.

D47225 HEALTH DEPARTMENT—CITY OF BALTIMORE D47225

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 W. West ST.; 23 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham Spriggs

(Residence in Baltimore: No. 105 W. West St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, January (Month) 1 (Day) (Year)

7-AGE, 51 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Rachel Spriggs

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Spriggs

(Address) 104 W. West

15-

Filed OCT 12 1920 191... ROBERT E. YEATES Registrar.

BURIAL PERMIT GIVEN

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 9 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 6 1920, to Oct 9 1920, that I saw him alive on Oct 7 1920, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Sclerosis

(Duration) (?) yrs. mos. ds.

(Signed) H. S. McCaul M. D.

10/11, 1920 (Address) 2005 E. Hillen

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cem. DATE OF BURIAL, Oct 12 1920

20-UNDERTAKER Samuel Hardy & Bro. ADDRESS 518 N. Gilmor

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047226 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047226

CERTIFICATE OF DEATH. 28V

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No Municipal Tuberculosis Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Davenport

(a) RESIDENCE. No 1129 Myrtle ave. ST.,..... WARD.....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edwin Davenport

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress D 86

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Taylor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Records
(Address) M.T.H.

15 Filed OCT 12 1920 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1920, to Oct. 10, 1920, that I last saw h er alive on Oct. 10, 1920, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum

(Signed) L. J. Rigney, M. D.

10-10-20. (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 13 1920
20 UNDERTAKER Samuel T Kemsley	ADDRESS 57 E Biddle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1046227

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047227

CERTIFICATE OF DEATH.

X 91-054

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James W Clarkson

(a) RESIDENCE. No. 407 Broad St. Charleston W Va ST., 12 WARD. Charleston W Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 27 - 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment In which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER J. W. Clarkson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) W Va

12 MAIDEN NAME OF MOTHER Ellen Meyers ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant (Address) J. H.

15 Filed OCT 12 1920 16 ROBERT E. LEAVELL Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1920, to Oct 11, 1920, that I last saw him alive on Oct. 11, 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

3 1/2 mos (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

3 1/2 mos (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? W. Va.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry M. Thomas Jr. M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charleston W Va	Oct 11 19[illegible]
20 UNDERTAKER Joseph Adrens	ADDRESS 221 N Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

647228 HEALTH DEPARTMENT—CITY OF BALTIMORE 647228

CERTIFICATE OF DEATH. X 45

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. University Hospital St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joshua Steward

(Residence ~~in Baltimore~~: No. Union Mills, Md, St.; ~~1~~ 62 yrs., 4 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH. January 5, 1858 (Month) (Day) (Year)

7-AGE. 62 yrs. 9 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Farmer
(b) General nature of Industry, business, or establishment in which employed (or employer). Farming.

9-BIRTHPLACE. (State or Country) Maryland.

PARENTS.

10-NAME OF FATHER. John Steward

11-BIRTHPLACE OF FATHER (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER. Mrs Wesner

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harvey Bankard

(Address) Westminster Md

15- OCT 12 1920 ROBERT B KRAUTER

Filed....., 191.... Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 11, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 2 1920, to Oct. 11 1920, that I saw him alive on Oct. 11 1920, and that death occurred, on the date stated above, at 6:15 Pm.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas - operation found to be inoperable after abdomen was opened.

..... (Duration) ....yrs. 12 mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

..... (Duration) ....yrs. ....mos. 1 ds.

(Signed) H. D. Bankard M. D.

Oct. 11, 1920 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 10 ds. In the State 62 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence Union Mills, Md.

19-PLACE OF BURIAL OR REMOVAL. Silver Run — DATE OF BURIAL. Oct. 14., 191.0

20-UNDERTAKER T. H. Bankard & Son — ADDRESS Westminster Md

N. B.—Every item of information must be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

d47229 HEALTH DEPARTMENT—CITY OF BALTIMORE 47229

CERTIFICATE OF DEATH. 78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3503 Barclay ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Fletcher

(a) RESIDENCE. No. 3503 Barclay ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Maria Brooks.

6 DATE OF BIRTH (month, day, and year) Feb 11, 1865

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55	7	29	

8 OCCUPATION OF DECEASED 070

(a) Trade, profession or particular kind of work Butler

(b) General nature of industry, business, or establishment in which employed (or employer) Private family

(c) Name of employer Isaac M. Cate

9 BIRTHPLACE (city or town) (State or country) Prince George Co., Md.

PARENTS

10 NAME OF FATHER Basil Fletcher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince George Co, Md.

12 MAIDEN NAME OF MOTHER Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince George Co, Md.

14 Informant Marian Fletcher (Address) 3503 Barclay St.

15 Filed OCT 12 1920 ROBERT P. LEE Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1920

17 I HEREBY CERTIFY, That I attended deceased from July, 1920, to Oct 10, 1920, that I last saw h[illegible] alive on Oct 9, 1920, and that death occurred, on the date stated above, at 11.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Prowse W. Hall, M. D.

10/11 1920 (Address) 2020 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Oct 12. 1920
20 UNDERTAKER Mrs Robert Elliott	ADDRESS 1725 Ashland Ave

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47230 HEALTH DEPARTMENT—CITY OF BALTIMORE D47230

CERTIFICATE OF DEATH.

REGISTERED NO. 81

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Mt Hope Retreat ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Conway

(a) RESIDENCE. NO. Phila. Pa ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	85 yrs	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer — 64 y
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Normandie England.

PARENTS

10 NAME OF FATHER Alfred Conway

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Margaret Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) Mt Hope Retreat

15 Filed OCT 12 1920 ROBERT E. [illegible] Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1920

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1854. ~~19~~ to Oct. 11 1920, that I last saw him alive on Oct 10. 1920, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis -
Post Atheroma Senile -
abt (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Mania -
abt (duration) 31 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Phila Pa

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Filaner M. D.

. 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Oct 13 1920

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D47231

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47231

CERTIFICATE OF DEATH.

54

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 S Hacker Ave St.; 1 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Reynolds

(Residence in Baltimore: No. 700 S Hacker Ave St.; 21 yrs., 10 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, November (Month) 16th (Day), 1898 (Year)

7-AGE.	If LESS than 1 day,
21 yrs. 10 mos. 23 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Sign Painter
(b) General nature of industry, business, or establishment in which employed (or employer)..... Painting

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, William J. Reynolds

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER Annie J. Hall

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm J. Reynolds

(Address) 700 S. Hacker ave

15- Filed OCT 12 1920, 191.... ROBERT E KRAUTER Burial Farm Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 9th (Month) (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25th 1920, to Oct 9th 1920, that I saw him alive on Oct 9th 1920, and that death occurred, on the date stated above, at 11.30 p m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Pernicious Anaemia

(Duration)....yrs. 3 mos....ds.

(Signed) W. H. Edmunds M. D.

Oct 11th, 1920 (Address) 734 S. Edmondson ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cem

DATE OF BURIAL, Oct 12, 191..

20-UNDERTAKER Stephen J. Hackerman

ADDRESS 100 S. Howard St

R. R.—Every item of information should be carefully supplied. Add month or year if not known exactly. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

047232 HEALTH DEPARTMENT—CITY OF BALTIMORE 047232

CERTIFICATE OF DEATH. 154

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 933 Madison ave ST.; 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Blackwell

(Residence in Baltimore: No. 933 Madison ave (If not, 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, white | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, June (Month) 30 (Day), 1828 (Year)

7-AGE, 91 yrs. 3 mos. 11 ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Somerset Co. Md.

PARENTS.

10-NAME OF FATHER, John D. Anderson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Jane Adams

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Flora E. Lanigey

(Address) 933 Madison ave

15- Filed OCT 12 1920, 191 ROBERT B KRAUTER Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 11th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 8 191, to Oct 11 1920, that I saw h[er] alive on Oct 8 1920, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) W. H. H. Pearce, M. D.

Oct 11, 1920. (Address) 2405 N. Charles st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. | In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery | DATE OF BURIAL, Oct 13, 1920

20-UNDERTAKER, Chas. D. Black | ADDRESS 742 W. North ave

No. 15.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47233 HEALTH DEPARTMENT—CITY OF BALTIMORE 146 D47233

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kathryn Meyer.

(a) RESIDENCE. NO. Old Pimlico Road. Mt. Washington ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George B. Meyer

6 DATE OF BIRTH (month, day, and year) March 23-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Gustav Kellerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Storm Harper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George B. Meyer (Address) Mt. Washington

15 Filed OCT 12 1920, 19.. ROBERT E. LEATHERY Registrar

Burial Permit Oct 13

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 11 1920

17 I HEREBY CERTIFY, That I attended deceased from September 4, 1920, to October 11, 1920, that I last saw h[er] alive on October 11, 1920, and that death occurred, on the date stated above, at 10° P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Osteomyelitis (R. femur).

Acute Endocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Streptococcus Septicemia

(duration) yrs. mos. 37 ds.

18 Where was disease contracted if not at place of death? At residence.

Did an operation precede death? Yes. Date of Sept. 7 1920

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam. & Laboratory

(Signed) E. Leitbur Stewart. M. D.

10/11, 1920 (Address) Maryland General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem.	Oct 14 1920
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47234

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47234

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2820 St Paul St ST.; 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Jane Dennett

(a) RESIDENCE. NO. 2820 St Paul St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry Dennett

6 DATE OF BIRTH (month, day, and year) April 6, 1846

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
73	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md

PARENTS

10 NAME OF FATHER Samuel Chrest

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Elizabeth Pickett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Harry Kummer
(Address) 2820 St Paul St

15 Filed OCT 12 1920 ROBERT B. BEAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11th 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1920, to Oct 11th, 1920, that I last saw h.. alive on Oct 11th, 1920, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) A. C. Emrich, M. D.

(Address) 4309 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Windfield Carroll Co. Md.	Oct 13 1920
20 UNDERTAKER	ADDRESS
H. Sander Sons	1210 Ruxtt

NOTE.—All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47235 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D47235

CERTIFICATE OF DEATH. X 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3063 Stafford St. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie E. Jackson

(a) RESIDENCE. No. 3063 Stafford ST., WARD. Seven Allen Md

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew Jackson

6 DATE OF BIRTH (month, day, and year): Oct. 15 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): A. A. Co Md

PARENTS

10 NAME OF FATHER: Hamilton Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): A. A. Co Md

14 Informant: Andrew Jackson

(Address) 3063 Stafford St

15 Filed OCT 12 1920 ROBERT E KRAUTER Registrar

Burial Permit Oiss

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 6. 20 to Oct 11 .

that I last saw h— alive on Oct 11 .

and that death occurred, on the date stated above, at 10.15 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Not Known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Howard W Jones M. D.

10 11 1920 (Address) 222 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jackson Grove A A Co Md	Oct. 15 1920
20 UNDERTAKER	ADDRESS
William Cook	502 E Natl Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

1047236 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047236

CERTIFICATE OF DEATH.

43

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Riggs Av ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Betsy Ham

(Residence in Baltimore: No. 1102 Riggs Av St.) 52 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, June 30, 1844 (Month) (Day) (Year)

7-AGE, 76 yrs. 3 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 070

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Thompson

(Address) 1102 Riggs Ave

15- OCT 12 1920 ROBERT B. KRAUTER

Filed..... 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 10, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8-1 1920, to 10/10 1920, that I saw h[illegible] alive on 10/10 1920 and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast +

A. Joints - extremity

(Duration) yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Arm. P. Butler M. D.

10/10 1920 (Address) 2139 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Md. DATE OF BURIAL, Oct 14, 1920

20-UNDERTAKER, Wm. H. Glass Son ADDRESS 1400 Mosher St

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY. WITH UNFADING INK.

0047237 HEALTH DEPARTMENT—CITY OF BALTIMORE 0047237

CERTIFICATE OF DEATH

28

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 918 Ridgely st. ST.: 21 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William Heidinger

(Residence in Baltimore: No. 918 Ridgely st. St.: 20 yrs. --- mos. --- ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male.	White.	Married.

6 DATE OF BIRTH: November 16th. 1887, 1 (Month) (Day) (Year)

7 AGE: 32 yrs. 10 mos. 24 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Chafleur.
(b) General nature of industry, business, or establishment in which employed (or employer): 676

9 BIRTHPLACE (State or country): Philadelphia, Pa.

PARENTS

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (State or country): Do not know.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Helen Heidinger. (wife)

(Address) 918 Ridgely st.

15 OCT 12 1920 (Date) ROBERT F KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October 10th. 1920., 191 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8, 1920, 191, to Oct, 10, 1920 191, that I saw him alive on Oct. 10, 1920, 191, and that death occurred, on the date stated above, at 11.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration) 1 yrs. --- mos. --- ds

Contributory (SECONDARY) Exhaustion (Duration) ... yrs. ... mos. ... ds.

(Signed) H. M. Reinhardt M. D.

Oct 11th, 1920 (Address) 1017 S. Charles st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: Oct. 13, 1920

20 UNDERTAKER: Geo. C. Schmuck & Bro. — ADDRESS: 1101 Park Ave

Edwards

1047238 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047238

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Harbor Hospital (St.) 12 (Ward) 169

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earl De Witt Edmonds

(Residence in Baltimore: No. 309 Glenstreet St.) aft 2. (yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov 24 (Month) (Day), 1889 (Year)

7-AGE, 30 yrs. 11 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): C.&O.

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Earl D Edmonds

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Virginia Pitt

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna E Edmonds

(Address) 309 Glenstreet

15- Filed OCT 12 1920, 191.... ROBERT B KRAUSER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 7 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward Paul Snyder M. D.
(Coroner)

Oct 12 1920 (Address) 1820 Rhode St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mill Creek Wks Va

DATE OF BURIAL, Oct 13 1920

20-UNDERTAKER Wilbur W Sherwood

ADDRESS 1018 E Edmondson Av.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Garrott

1047239 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047239

81

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2405 Annah Ave St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Garrott

(Residence in Baltimore: No. 2405 Annah Ave St.; 3 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, August 1st, 1843 (Month) (Day) (Year)

7-AGE, 77 yrs. 2 mos. 11 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)..... 500

9-BIRTHPLACE, (State or Country), Frederick Co., Md.

PARENTS.

10-NAME OF FATHER, John Pearroth

11-BIRTHPLACE OF FATHER (State or Country), Fred'k Co. Md

12-MAIDEN NAME OF MOTHER Martha Hackney

13-BIRTHPLACE OF MOTHER (State or Country), Fred'k Co., Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Charles Garrott

(Address) 2405 Annah Ave

15- OCT 12 1920

Filed....., 191... ROBERT T. KRANTZ Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 11th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 4th 1920, to Oct 11th 1920, that I saw her alive on Oct 10th 1920, and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

Indefinite duration

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senile Pneumonia

Heart Failure

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eleanor C. Noel M. D.

10-12, 1920 (Address) 1012 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Catonsville Md. DATE OF BURIAL, 10/13/20

20-UNDERTAKER Jno C. Mitchell ADDRESS 1201 E Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

1047240

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047240

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 228 N. Chester St ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaac Kramer

(Residence in Baltimore: No. 228 N. Chester St.: 8 yrs., 6 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	White

6-DATE OF BIRTH, April (Month) 10 (Day), 1917 (Year)

7-AGE, 8 yrs. 6 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer): boy

9-BIRTHPLACE, (State or Country), Baltimore md

PARENTS.

10-NAME OF FATHER, Charles Kramer

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Yetta Krieger

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E Balto St

15- OCT 12 1920 Filed....., 191.....

ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 12 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 4 1920, to Oct 12 1920, that I saw h~ alive on Oct 11 1920, and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(Duration) months yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(Duration) some time yrs. mos. ds.

(Signed) A. T. Ries M. D.

Oct 12, 1920 (Address) 24 W 13 St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? ~ Baltimore

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Workmen Circle Cemetery

DATE OF BURIAL, Oct. 13, 1920

20-UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047241 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047241

CERTIFICATE OF DEATH.

REGISTERED NO. 15-41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1800 Clifton Ave. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Derr

(a) RESIDENCE. No. 1800 Clifton Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~XXXXX~~ Annie E. Derr

6 DATE OF BIRTH (month, day, and year) Oct. 3, 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72		7	

8 OCCUPATION OF DECEASED 0-86

(a) Trade, profession or particular kind of work Retired (Butter&Eggs

(b) General nature of Industry, business, or establishment in which employed (or employer) B.F. Hickman Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Taneytown Maryland

PARENTS

10 NAME OF FATHER Israel Derr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Crise

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Jessie I. Derr
(Address) 1800 Clifton Ave.

15 Filed OCT 12 1920, 19 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 19 20

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1920, to Oct 10, 1920, that I last saw him alive on Oct 10, 1920, and that death occurred, on the date stated above, at 1 P.M. The CAUSE OF DEATH* was as follows: Carcinoma of Duodenum

(duration) 1 yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Usual Examination

(Signed) Thomas Talbot M. D.

, 19 (Address) Marlborough Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bauer Cemetery Carroll Co Md	Oct 13 1920
20 UNDERTAKER Jos B Cook	ADDRESS 1003 W Balto

A. B. C. [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47242

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47242

63-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Windsor Court Apartments ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeleine Angela Morgan

(a) RESIDENCE. No. Windsor Court Apartments ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15, 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Harry J. Morgan

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Madeleine Custy

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant J. Edward Custy
(Address) Windsor Court Apartments

15 Filed OCT 12 1920 ROBERT E KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1920, to Oct 12, 1920, that I last saw h— alive on Oct 12, 1920, and that death occurred, on the date stated above, at 1.45 a m.

The CAUSE OF DEATH* was as follows:

Acute Poliomyelitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? St. Agnes College

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis? Spinal Fluid

(Signed) Edw. V Averbukh, M. D.

10/12, 1920 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Oct. 13 1920
20 UNDERTAKER	ADDRESS
J & B Cook	1003 Balto

N. B.—WHITE PAPER, WITH CARBON INSERTED, MUST BE USED. PHYSICIANS should be careful to see that all information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 47243 HEALTH DEPARTMENT—CITY OF BALTIMORE N 47243

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 169

CITY OF BALTIMORE (No. South Baltimore General Hospital St. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josef Nedlik.

(Residence in Baltimore: No. 819 Curtis Ave. Curtis Bay. St.; yrs. 12. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male.	White.	Do not know.

6-DATE OF BIRTH. Do not know. (Month), 1 (Day), ... (Year)

7-AGE. 50 yrs. ... mos. ... da. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer Chemical
(b) General nature of industry, business, or establishment in which employed (or employer): Construction Co.

9-BIRTHPLACE, (State or Country), Bohemia.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katie Varholl.

(Address) 819 Curtis Ave Curtis Bay.

15- OCT 13 1920 ROBERT I KRAUTER
Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 8th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an in.c.r.& autps. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said in.c.r. & autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Accidental fall from a scow.
Shock, incomplete resuscitation.
(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) .....
(Duration) ... yrs. ... mos. ... da.

(Signed) Otto M. Fennhardt M. D.
(Coroner.)

Oct 12., 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death? Chemical Construction Co. Curtis Bay.

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Bed of Pitt	Oct 15 ....., 19....
20-UNDERTAKER Frank Lynch & Son	ADDRESS 1966 Mount Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PAPER, WITH UNFADING INK — THIS STATEMENT RECORD

D47244 HEALTH DEPARTMENT—CITY OF BALTIMORE D47244

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 571

CITY OF BALTIMORE (No. Rear 1130 Lemmon ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Lewis

(Residence in Baltimore: No. 1130 Lemmon St. St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col.	Sgl.

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, ... yrs. 2 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Frank Lewis

11-BIRTHPLACE OF FATHER (State or Country), U. Va.

12-MAIDEN NAME OF MOTHER Mary Jones

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Lewis

(Address) 1130 Lemmon

15- OCT 13 1920 ROBERT B KRAUTER

Filed ....., 191.... Burial Permit Issued Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 11, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Oct. 13, 1920 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Asbury	Oct 13, 1920
20-UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

Remarks

No marks of violence. Coroner could give no history of cause of convulsions

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home, and* children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho-pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hæmorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyæmia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicæmia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047245 HEALTH DEPARTMENT—CITY OF BALTIMORE 047245

CERTIFICATE OF DEATH.

REGISTERED NO. 19

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Preston Valley Sts ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine O'Rourke.

(a) RESIDENCE. No. Little Sisters of the Poor. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow of

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James O'Rourke

6 DATE OF BIRTH (month, day, and year) July 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	2	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Patrick Roche

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Foley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Sister Florence

(Address) Little Sisters of the Poor

15 Filed OCT 13 1920 ROBERT B. KRAUTER, Registrar

Burial Permit Oiert

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1920

17 I HEREBY CERTIFY, That I attended deceased from No record, 19 , to , 19 ,

that I last saw her alive on Oct 11 , 1920 ,

and that death occurred, on the date stated above, at 12.05 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

Oct 12, 1920 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Oct 13 1920

20 UNDERTAKER H. C. Wiedefeld ADDRESS 914 Greenmount Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE CLEARLY, WITH UNFADING INK—

Spec.—6-9-19—H. P. Co.—1000 Bks.

647246

HEALTH DEPARTMENT—CITY OF BALTIMORE

647246

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 116 Scott St. 19 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy E Jacobs

(a) RESIDENCE. No. 116 Scott St., 21 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6-1920

7 AGE: Years | Months: 4 | Days: 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Chas Jacobs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Mary Hart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Chas Jacobs (Address) 116 Scott St

15 Filed OCT 13 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 12 19 20 to Oct 12 19 20

that I last saw h alive on Oct 12 1920

and that death occurred, on the date stated above, at p.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J Schwerzsky M. D.

19 (Address) 1120 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery | DATE OF BURIAL: Oct. 13th 1920

20 UNDERTAKER: Mr & Mrs John W. Teufel | ADDRESS: 801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other infection

Spec.—6-9-19—H. P. Co.—1000 Bks.

1947247

HEALTH DEPARTMENT—CITY OF BALTIMORE

1947247

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 146 W Hamburg ST. 23 WARD)

2-FULL NAME. Maggie Gantt

(a) RESIDENCE. NO. 146 W Hamburg ST., 23 WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) General Employment
(c) Name of employer md

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Thomas Gantt

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Victoria Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Victoria Gantt
(Address) 146 W Hamburg

15 Filed OCT 13 1920 ROBERT B [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/11/20.

17 I HEREBY CERTIFY, That I attended deceased from 8/30/20, to 10/11/20.
that I last saw her alive on 10/11/20.
and that death occurred, on the date stated above, at 1.150 m.

The CAUSE OF DEATH* was as follows:

Acute myocarditis
about 5 ds.
(duration)
CONTRIBUTORY (Secondary) Pulmonary Tbc
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Kenneth Bowley M. D.
10/11/20 (Address) 908 S Eliot St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Oct 13 1920

20 UNDERTAKER John H. Toadvine

ADDRESS 142 N Fulton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Nellie Goldstein

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D47248 — 79 — D47248

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1626 ST. Mulliken 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Goldstein

(Residence in Baltimore: No. 1626 Mulliken St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Unknown, 1825
(Month) (Day) (Year)

7-AGE, 95 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman

(Address) 1411 Eager St

15- OCT 13 1920 ROBERT B KRAUTER
Filed....., 191.....
Burial Permit Issued Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 12 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation Cardiac

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Linder M. D.
(Corner)
10 00 (Address) Federal

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Arlington Washington Co	Oct 13 1920
20-UNDERTAKER	ADDRESS
Jos Lewis	1411 E. Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047249

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047249

CERTIFICATE OF DEATH.

115-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Myrtle 1001 ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Novak

(a) RESIDENCE. NO. 2110 Jefferson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 2 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Teresa Novak

6 DATE OF BIRTH (month, day, and year) Aug 7 - 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer D.F.D.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Novak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Barbara Kajik

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Theresa Novak

(Address) 2110 Jefferson st

15 Filed OCT 13 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/11 1920

17

I HEREBY CERTIFY, That I attended deceased from 10/10 . 1920 , to 10/11 . 1920 , that I last saw him alive on 10/11 . 1920 , and that death occurred, on the date stated above, at 9.50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lewis D. Ridgely, M. D.

10/11. 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Oak Hill	Oct 14 1920
20 UNDERTAKER	ADDRESS
Frank Frank & Son	1906 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047250 HEALTH DEPARTMENT—CITY OF BALTIMORE 047250

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3332 Chestnut Ave ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nelson Kidd

(a) RESIDENCE. NO. 3332 Chestnut Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? birth yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) June 14 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper 088

(b) General nature of industry, business, or establishment in which employed (or employer) Pool Engineer

(c) Name of employer Balto Co

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John A. Kidd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Margaret Hetrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Frank Kidd

(Address) 1033 N Smallwood St

15 Filed OCT 13 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to Oct 12, 1920, that I last saw h alive on Oct 11 1920, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

Contributory Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 4 mos. + ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs

(Signed) R B Norwood, M. D.

10.13. 1920 (Address) 3543 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hanfkd.	Oct 14 1920

20 UNDERTAKER A S Marshall ADDRESS 3539 Fall Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

S. A. FE

DAK

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47251 HEALTH DEPARTMENT—CITY OF BALTIMORE D47251

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1360 N Carey ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Blanche Dyson

(a) RESIDENCE. NO. 1360 N. Carey ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Edward Dyson

6 DATE OF BIRTH (month, day, and year) Sept 1, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self,

9 BIRTHPLACE (city or town) (State or country) St Mary's Co, Leonardstown,

PARENTS

10 NAME OF FATHER James ? Brown,

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co

12 MAIDEN NAME OF MOTHER Anna Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys

14 Informant Hugh B. Dyson

(Address) 1360 Carey

15 Filed OCT 13 1920 ROBERT B. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 19 20

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 19 20, to Oct 12, 19 20, that I last saw h alive on Oct 11, 19 20, and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? City.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Wm H. Wright M. D.

(Address) Wm. H. Wright

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Oct 14th 1920

20 UNDERTAKER Clarence E. Wright ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47252

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47252

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1736 Carswell ST.: 9 WARD)

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine E. Young

(a) RESIDENCE. No. 1736 Carswell ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) March 2, 18—1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Umbrella Tipper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Gans Bros.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Robert B. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Annie E. Winters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Geo. E. Black
(Address) 2407 Elsinore Ave.

15 Filed OCT 13 1920 . 19 ROBERT N KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11th 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 5th, 1920, to Oct. 11th, 1920, that I last saw her alive on Oct. 10th, 1920, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease
Aortic Insufficiency
(duration) 6 yrs. — mos. — ds.

* * * *

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? * * * *

Did an operation precede death? no Date of * * *

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Edw. N. Swigerald, M. D.

10/12 1920 (Address) 5 N. Washington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery.	10/13 1920
20 UNDERTAKER	ADDRESS
C. F. Evans & Son.	116 W. Lexington Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47253

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47253

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 S. East Ave ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Morton

(a) RESIDENCE. No. 730 S. East Ave. ST., 76 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Emma Morton

6 DATE OF BIRTH (month, day, and year) June 20-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Navy Department. Washington.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER Hamilton Morton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila. Pa.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Gustav Voss

(Address) 730 S. East ave.

15 Filed OCT 13 1920 ROBERT B. LEAUTEN Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 11 1920

17

I HEREBY CERTIFY, That I attended deceased from 9/1/20, 19, to 10/11/20, 19, that I last saw h[illegible] alive on 10/11/20, 19, and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH* was as follows: —

Cerebral Hemorrhage

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) nour

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. J. Norriman, M. D.

10/12/20, 19 (Address) 719 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Oct. 13 1920
20 UNDERTAKER Lilly & Zeiler.	ADDRESS 403 W Mulb

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D47254

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47254

CERTIFICATE OF DEATH.

REGISTERED NO. 99

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 835 Druid Hill Av ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Knight

(a) RESIDENCE. No. 835 Druid Hill Av ST., 17 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 9 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Boston H. Knight

6 DATE OF BIRTH (month, day, and year): Jan 26-1866

7 AGE: 54 Years | 9 Months | 4 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Boston H. Knight (Address) 835 Druid Hill Ave

15 Filed OCT 13 1920 ROBERT E. LEE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 11 1920

17 I HEREBY CERTIFY, that I attended deceased from Sept 4, 1920, to Oct 4th, 1920, that I last saw h[illegible] alive on Oct 10, 1920, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary): Ex Rheumatism

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Stethoscope & Symptoms

(Signed) S. [illegible] Hughes M.D.

Oct 12 1920 (Address) 1413 Druid Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft Auburn Cem'y	Oct 14 1920
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Orleans Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 047255 ~ 047255 ~ 120

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Wilkins Ave ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. James T. Doyle

(a) RESIDENCE. No. 4211 Connecticut Ave. Irvington WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) Mrs Mary Doyle

6 DATE OF BIRTH (month, day, and year) Unknown 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Daniel Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catharine Treacy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary E. Doyle (Address) 27 Eutaw St

15 Filed OCT 13 1920 ROBERT E. KLAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1920

17 I HEREBY CERTIFY, That I attended deceased from 9/27/20, 19 , to 10/12/20, 19 , that I last saw him alive on 10/12/20, 19 , and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia of Chr. Interstial Nephritis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) W. M. Craig, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Oct 13 1920
20 UNDERTAKER H. C. Holmes & Sons	ADDRESS Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47256 ✓ D47256

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47256

CERTIFICATE OF DEATH.

151 015 1st Ward C.D.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 S Bond ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Stillborn~~ Peter & Dorthy Zurek

(a) RESIDENCE. No. 603 S Bond ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 12-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Peter Zurek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Dorthy Kubiak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Peter Zurek (Address) 603 S Bond St

15 Filed OCT 13 1920 ROBERT J. KRAFFT Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 12th, 1920, to Oct 12th, 1920, that I last saw him ~~alive~~ on — , 1920, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Premature birth
(7 months)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. L. Wisner, M. D.

10/12 1920 (Address) 308 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 13 1920

20 UNDERTAKER John J. A Weber ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47257

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47257

CERTIFICATE OF DEATH.

1082

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Brown

(a) RESIDENCE. NO. Y. M. C. A., ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7-1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Govmt Employee

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Camp Holabird

9 BIRTHPLACE (city or town) (State or country) Boston Mass

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) J. M. Chapman Y. M. C. A.

15 Filed OCT 13 1920 ROBERT B. CHANTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1920, to Oct 12, 1920, that I last saw him alive on Oct 12, 1920, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Appendicitis & Cholecystitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Sept.

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard B. McElwain, M. D.

. 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boston Mass

DATE OF BURIAL Oct 13 1920

20 UNDERTAKER J. Pinner & Bro

ADDRESS 1127 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47258

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D47258

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2654 Florence (St.:) 13 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Williams

(a) RESIDENCE. No. 2654 Florence St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Baby

6 DATE OF BIRTH (month, day, and year): 17 April 1920

7 AGE — Years: — Months: 5 Days: 23 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Charles Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eizzie Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Charles Williams (Address) 2654 Florence St.

15 Filed ..... 19 ..... Registrar

OCT 13 1920

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/11 1920

17 I HEREBY CERTIFY, That I attended deceased from 10/5 1920, to 10/11 1920, that I last saw h[illegible] alive on 10/10 1920, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

A. Gastro-enteritis

(with Bloody Dysentary)

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Burt Rhett, M. D.

, 19 (Address) 239 Dk. Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Oct 13 1920

20 UNDERTAKER: Edw. Ringgold — ADDRESS: 1463 Carey St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly coded. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Julielma Camp

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47259 ✓ 64 D47259

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 John St.; 14 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julielma Camp

(Residence in Baltimore: No. 1505 John St. St.; 24 yrs., X mos. X ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, 1 (Month) 23 (Day), 1837 (Year)

7-AGE, 83 yrs. 8 mos. 19 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Brandywine - Del.

PARENTS.

10-NAME OF FATHER, John Elliott

11-BIRTHPLACE OF FATHER (State or Country), Delaware

12-MAIDEN NAME OF MOTHER Sarah Hollingsworth

13-BIRTHPLACE OF MOTHER (State or Country), Delaware

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ida H. Perkins

(Address) 1505 John St.

15- ROBERT B KRAUTZ

Filed OCT 13 1920 191. Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 12 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15 1920, to Oct. 12 1920, that I saw her alive on Oct. 11 1920, and that death occurred, on the date stated above, at 3:10 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (right Hemiplegia) 2nd attack -
(1st attack May 15, 1920)

(Duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) yrs. mos. ds.

(Signed) P B Wilson M. D.

10/12, 1920. (Address) 1124 W Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenhill Mem. — DATE OF BURIAL, Oct 15, 1920.

20-UNDERTAKER Compton — ADDRESS 502 E Monument

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Emma Weinkauf

D 47260

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47260

CERTIFICATE OF DEATH.

1562

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1834 E. Chase St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Weinkauf

(Residence in Baltimore: No. 1834 E. Chase St. St.: yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem'e

4-COLOR OR RACE: Wh

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH: June (Month) 24 (Day), 1861 (Year)

7-AGE: 89 yrs. 3 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Spinster
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Not Known

11-BIRTHPLACE OF FATHER (State or Country): Not Known

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (State or Country): Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Wm. R. Sandiman

(Address) 1834 E. Chase St

15- ROBERT B. LEMMON

Filed OCT 13 1920, 191.... Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Oct (Month) 12 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Coronary Sclerosis

Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. R. Stanley M. D.
(Coroner)

Oct 12, 1920 (Address) 13 E. Lex St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: Oct 15 1920

20-UNDERTAKER: Henry Storck Son

ADDRESS: 130 E Eager St

Spec.—6-9-19—H. P. Co.—1000 Blks.

D47261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47261

CERTIFICATE OF DEATH.

104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1320. Reynold ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose M. Lonczynski

(a) RESIDENCE. No. 1320. Reynold ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of " "

6 DATE OF BIRTH (month, day, and year) Dec 26-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work " "

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Lonczynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Pietzak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Joseph Lonczynski
(Address) 1320 Reynold

15 Filed ... 19 ... ROBERT F. KRAUTER Registrar
OCT 13 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1920, to Oct 12, 1920, that I last saw h[illegible] alive on ..., and that death occurred, on the date stated above, at 4 4' m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) ... yrs. ... mos. 20 ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? ...

(Signed) A. J. Freedam, M. D.

, 19 (Address) 918 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	10/14 19 20

20 UNDERTAKER Wm Fiedtsou 14 168 Eastern ave.

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47262 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D47262

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 Aliceanna St.: 3 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wiktorya Polek.

(a) RESIDENCE. No. 1510 Aliceanna St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of " "

6 DATE OF BIRTH (month, day, and year) Feb. 26- 1920

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Simon Polek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Mary Monka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Simon Polek

(Address) 1510 Aliceanna

15 Filed OCT 13 1920 19 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1920, to Oct 12, 1920, that I last saw h— alive on Oct 12, 1920 and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Acute gastro Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Wilenkin, M. D.

(Address) #2 n Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	10/14 1920
20 UNDERTAKER	ADDRESS
William Fallsowski	1018 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

47263

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 47263

CERTIFICATE OF DEATH.

X 41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST.; 20 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene Lawrence

(Residence in Baltimore: No. Ivanville Md. St.; ....yrs.,....mos.....ds.)

N.B.—Every item of information should be carefully supplied. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, March (Month) 4 (Day), 1859 (Year)

7-AGE, 51 yrs. 7 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jno Lawrence

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Clara Carter

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. Lawrence Brp

(Address) Ivanville Md.

15-

Filed OCT 13 1920, 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 13 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 17 1920, to Oct 13 1920, that I saw him alive on Oct 13 1920, and that death occurred, on the date stated above, at 11:45 A.m.

The CAUSE OF DEATH* was as follows:

Tumor (Sarcoma?)
of pelvic viscera
Abdominal wall

(Duration) yrs. 2 mos. 20 ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) S. Lloyd Johnson M. D.

....., 191... (Address) Bons Secours Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 2 mos. 26 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Ivanville, Md.

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Lebanon Cem MD — DATE OF BURIAL: Oct 13 1920

20-UNDERTAKER: George W. Fuhrman — ADDRESS: Fulton & Forsyth

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47264

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47264

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 W 25th St. St. 12 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia C Houck

(a) RESIDENCE. No. 412 W 25th St. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Houck

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John W Craig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Hutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Effie Houck (Address) 412 W 25th St

15 Filed OCT 13 1920, 19 Robert T. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 4, 1919, to Oct 12, 1920, that I last saw her alive on Oct 12, 1920, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis; with Cerebral Hemorrhage (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urinalysis & Blood Pressure tests

(Signed) H. Shelley, M. D.

10/12, 1920 (Address) 3849 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Oct 14 1920

20 UNDERTAKER Chenoweth & Son ADDRESS Chestnut St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47265 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47265

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3929 Roland Ave. 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeannie Stokes

(a) RESIDENCE. NO. 3929 Roland Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Stokes

6 DATE OF BIRTH (month, day, and year) Jan 23 1895

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
25	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James Wine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Adoie Wine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant David Stokes (Address) 3929 Roland Ave

15 Filed OCT 13 1920, 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13. 1920

17 I HEREBY CERTIFY, That I attended deceased from August 3 1920, to October 12 1920, that I last saw h e alive on October 12, 1920, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exposure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. J Danes, M. D.

10/13 1926 (Address) A. J Danes Chestnut Ave Govans 33 Md 31

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Oct 15 1920
20 UNDERTAKER	ADDRESS
Ehenowerth Son	Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

143742 1047266

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047266

CERTIFICATE OF DEATH.

X 130

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. N/S WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Nobles

(a) RESIDENCE. No. 33 St Paul Between 8th & 9th ST. Fairfield WARD. North Carolina

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. 44 mon. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor.

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown. (State or country)

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant J. H. Rhunds

(Address)

15 Filed OCT 14 1920, 19 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 11, 1920, to Oct 12, 1920, that I last saw h alive on Oct 12, 1920, and that death occurred, on the date stated above, at 10 45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Uraemia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. R. Mason M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rockville M. C.	Oct 14 1920
20 UNDERTAKER	ADDRESS
S L Brown & Son	1011 N. Monty

B & O. R.R.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1047267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1047267

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Home for Incurables St.: 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Lillie B. Bramble

(Residence in Baltimore: No. Home for Incurables 21st & Guilford Ave. St.: 15 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Single

6 DATE OF BIRTH June (Month) 15 (Day), 1852 (Year)

7 AGE 68 yrs. 3 mos. 25 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Kent Co Md

PARENTS

10 NAME OF FATHER Henry Bramble

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susanna Coleman

13 BIRTHPLACE OF MOTHER (State or country) Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Rose Bramble

(Address) 1830 Harlem Ave

15. Filed OCT 14 1920, 19.. ROBERT B KRAUTER REGISTRAR

Burial Form [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct (Month) 13th (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August, 1920, to Oct 13th, 1920, that I saw h.e.r alive on Oct 11th, 1920, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ? yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas L. Sheary M. D.

Oct 15th, 1920. (Address) 926 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Chestertown Md	Oct 14, 1920
20 UNDERTAKER JOHN F. DENNY	ADDRESS 715 LIGHT ST.

Spec.—8-24-14—M. & T.—2000 Blks.

647268

HEALTH DEPARTMENT—CITY OF BALTIMORE

647268

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1029 N Wolfe St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Stanley Gaddess

(Residence in Baltimore: No. 1029 N Wolfe St.; ....yrs., 1 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, Sept 10, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 2 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Winfield Gaddess

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Serena Maddox

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Serena Gaddess

(Address) 1029 N Wolfe St.

15- OCT 14 1920 ROBERT B KRAUTER

Filed....., 191.....
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1920, to October 12 1920, that I saw h[im] alive on October 11th 1920, and that death occurred, on the date stated above, at 11 45 a m.

The CAUSE OF DEATH* was as follows:

Traumatism Baby fever
Nursed and took Cold Very
little Nourishment

(Duration) ....yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Starvation

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thomas J. Timmes M. D.

Oct. 13, 1920. (Address) 1025 N Wolfe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Oct 14, 1920

20-UNDERTAKER Mrs J. S. Locke ADDRESS 1302 Ellsworth

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write PLAINLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

947269

HEALTH DEPARTMENT—CITY OF BALTIMORE

947269

CERTIFICATE OF DEATH.

X 120

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 24 S. Carrollton Ave ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H. Lannamon

(Residence in Baltimore: No. 24 S. Carrollton Ave. St.; ... yrs., 7 mos. ... dz.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Dec. (Month) 23d (Day), 1849 (Year)

7-AGE, 70 yrs. 9 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Delaware

PARENTS.

10-NAME OF FATHER, Thomas Lannamon

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Lannamon

(Address) 24 S. Carrollton Ave

15- OCT 14 1920 ROBERT B KRAUTER

Filed ..... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 13th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1st 1920, to Oct 13th 1920, that I saw h[illegible] alive on October 13th 1920, and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

1 Myocarditis and
Chronic Interstitial Nephritis

(Duration) ... yrs. 10 mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) ... yrs. ... mos. 3 ds.

(Signed) J. B. Carter Brown M. D.

10/13, 1920 (Address) 1200 under Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. 4 mos. ... ds. In the State 44 yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Shelltown Md

Former or usual residence Shelltown Md

19-PLACE OF BURIAL OR REMOVAL, Rehoboth Baptist Church Cemetery Interment to me

DATE OF BURIAL, Oct 17, 1920

20-UNDERTAKER George J. Smith

ADDRESS 25 E Fayette St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47270 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D47270

87

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615. Sheakspeare ST.: W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stefania Filipkowska

(a) RESIDENCE. NO. 1615. Sheakspeare ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: "

6 DATE OF BIRTH (month, day, and year): Aug 3-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer): " "

(c) Name of employer: " "

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Joseph Filipkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mal Dzygorka

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Joseph Filipkowski 1615 Sheakspeare

15 Filed OCT 14 1920 16 ROBERT B KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12 1920, to Oct. 13. 1920, that I last saw h.w alive on Oct. 13 1920, and that death occurred, on the date stated above, at 4½ P. m.

The CAUSE OF DEATH* was as follows:

I. Acute Laryngitis DBN

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) /

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) John H. Rehberger, M. D.

, 19 (Address) 1709 Aliceanna St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary.

DATE OF BURIAL: Oct 14 1920

20 UNDERTAKER: Wm Fallowsky

ADDRESS: 168 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 47271

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47271

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 835 S. Bond. (St.:) W (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helena Andrychowska.

(a) RESIDENCE. No. 835 S. Bond St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 16-20

7 AGE: Years ... Months 8 Days 28 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none 000
(b) General nature of Industry, business, or establishment in which employed (or employer): "
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Antoni Andrychowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Elharis Majka

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Antoni Andrychowski.
(Address) 835 S Bond St

15 Filed OCT 14 1920, 19 ... ROBERT E. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1920, to Oct 12, 1920, that I last saw h[illegible] alive on Oct. 11, 1920, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) /

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John H. Rehberger, M. D.

. 19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: 10/14/1920

20 UNDERTAKER: Mt Faircourt — ADDRESS: 1618 Eagle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably broncho pneumonia. No further history.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

047272 047272 120

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Ettting ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Anny Hackett

(Residence in Baltimore: No. 1102 Ettung St.; 70 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWER, OR DIVORCED, (Write the word.)
Female	Colored	married

6-DATE OF BIRTH, Feb. (Month) 14 (Day), 1858 (Year)

7-AGE,	If LESS than 1 day,
62 yrs. 7 mos. 27 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 437

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Collin Carpenter

11-BIRTHPLACE OF FATHER (State or Country), Unknown.

12-MAIDEN NAME OF MOTHER Elizabeth Sorrell

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Scott

(Address) 1102 Ettung St.

15- Filed OCT 14 1920, 191.... ROBERT F. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 11 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 2 1920, to Oct. 11 1920, that I saw her alive on Oct. 11 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(Duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Cons.

(Duration) .... yrs. .... mos. 10 ds.

(Signed) A. H. Robinson M. D.

Oct. 13, 1920 (Address) 1307 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	Oct. 14, 1920
20-UNDERTAKER John H. Bradin	ADDRESS 17 W. Hill St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47273 D47273

CERTIFICATE OF DEATH.

54

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2660 Presbury ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice M. Hubbard

(Residence in Baltimore: No. 2660 Presbury St. St.: 17 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July 13, 1883 (Month) (Day) (Year)

7-AGE, 37 yrs. 3 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Dorchester Co Md

PARENTS.

10-NAME OF FATHER, Benjamin F Tall

11-BIRTHPLACE OF FATHER (State or Country), Dorchester Co Md

12-MAIDEN NAME OF MOTHER Mary E. Fitton

13-BIRTHPLACE OF MOTHER (State or Country), Harpers Ferry Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Hubbard

(Address) 2660 Presbury St

15- OCT 14 1920 ROBERT B. BRAUTIGAM

Filed ....., 191.... BUREAU OF VITAL STATISTICS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 13, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1920, to Oct. 13 1920, that I saw her alive on Oct. 13, 1920, and that death occurred, on the date stated above, at 1:50 p.m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. 9 mos. ds.

(Signed) E. A. Dickey M. D.

Oct 13, 1920. (Address) 14 N. Thousand St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cambridge Md

DATE OF BURIAL, October 14 1920

20-UNDERTAKER William Cook

ADDRESS 502 E. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1047274 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047274

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2644 Hampden ave St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. James J Riggs

(Residence in Baltimore: No. 2644 Hampden ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, Wa

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... Mar (Month) 31 (Day) 1849 (Year)

7-AGE, 71 yrs. 6 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: 015

(a) Trade, profession, or particular kind of work ..... Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) ..... retired

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Riggs

11-BIRTHPLACE OF FATHER (State or Country) Balto

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James J Riggs

(Address) 2644 Hampden ave

15- Filed OCT 14 1920, 191.... ROBERT B KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct (Month) 12 (Day) 1920 (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypostatic Congestion

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) John Harrison M. D.

Oct 12, 1920 (Address) 7632 Roland ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel

DATE OF BURIAL, Oct 15, 1920

20-UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047275 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047275

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 811 S. Potomac ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Croney

(a) RESIDENCE. No. 811 S. Potomac ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie G. Croney

6 DATE OF BIRTH (month, day, and year) April 11 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sail Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. W. Croney

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Kirk

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Minnie G. Croney

(Address) 811 S. Potomac St

15 Filed OCT 14 1920 19... ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13 1920

17

I HEREBY CERTIFY, That I attended deceased from ~~Sept~~ Oct 9th 1920 to Oct 12th 1920

that I last saw him alive on Oct 12th 1920

and that death occurred, on the date stated above, at 1 25 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. C. Schwatka M. D.

10/13/1920 (Address) 734 S Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz's Cemetery	Oct. 15 1920
20 UNDERTAKER	ADDRESS
Zirkler + Zirkler	1739 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dehoney.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47276 HEALTH DEPARTMENT—CITY OF BALTIMORE D47276

CERTIFICATE OF DEATH. 37

1-PLACE OF DEATH Bayview Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elzie Dehoney

(a) RESIDENCE. NO. 1314 W. 20th ST., WARD. Indiana

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1870?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
50?				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10 NAME OF FATHER Do.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant Bayview Hospital (Address) Record.

15 Filed OCT 14 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 6 1920 to Oct 12, 1920.

that I last saw him alive on Oct 12, 1920.

and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Insane)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Entire Depletion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? by symptoms

(Signed) H. L. Hedrick M. D.

10/13/1920 (Address) Bayview Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 16th 1920
20 UNDERTAKER Joseph A Farrell	ADDRESS 2318 Pinkney

N. B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. ANY item left incomplete. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47277

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D 47277

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 W Montgomery ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clyde Foreman

(a) RESIDENCE. No. 4 W. Montgomery ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 22 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bootblack 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer own business Howard Co. Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John Foreman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Agnes Robinson
(Address) 4 W. Montgomery St

15 Filed OCT 14 1920 ROBERT B. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1920, to Oct. 12, 1920, that I last saw him alive on Oct. 12, 1920, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart.

(duration) 4 yrs. 2 mos. 6 hrs.

CONTRIBUTORY (Secondary) Aneurism of Abdominal Aorta, Aortic Insufficiency (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Only Clinical Tests

(Signed) D. H. Lamee, M. D.

, 19 (Address) 140 N. Hall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary Cemetery	Oct. 15 1920
20 UNDERTAKER R. L. Parham	ADDRESS 649 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Luetic.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 47278

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42 D 47278

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 Park ave ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Robinson

(a) RESIDENCE. No. 1027 Park ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Edward P Robinson

6 DATE OF BIRTH (month, day, and year): 1872

7 AGE: Years 48; Months; Days; If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Norfolk Va

PARENTS

10 NAME OF FATHER: Moses Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Margaret Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Edward P. Robinson
(Address) 1027 Park Ave

15 Filed OCT 14 1920 ROBERT B KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/11/1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1920, to Oct. 11, 1920.

that I last saw h.EV alive on Oct. 10, 1920

and that death occurred, on the date stated above, at 2 8 m.

The CAUSE OF DEATH* was as follows:

Uterine Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Uterine Fibromyoma about

(duration) yrs. 10 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Jno. H. Tompkins, M. D.

19 (Address) 1019 Dulaney Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem — DATE OF BURIAL: Oct 14 1920

20 UNDERTAKER: Saunders & Beasley — ADDRESS: 718 N Bradley

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 47279

1262 47279

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 E Chase st St.: 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorenz Krieger

(a) RESIDENCE. No. 408 E Chase St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18th 1830

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mark Krieger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jr Adolph Krieger (Address) 408 E Chase st

15 Filed ....., 19..... Registrar

ROBERT F. KRAUTER

OCT 14 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 11th, 1920, to Oct 12th, 1920, that I last saw him alive on Oct 12th, 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Prostatic Hypertrophy

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examinations

(Signed) William J. Nessick, M. D.

Oct 13 1920 (Address) 1700 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 15th 1920
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. NAME AND RESIDENCE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION and TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47280

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47280

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3814 Ashburton Ave ST. 15 WARD)

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary P. Luttrell

(a) RESIDENCE. No. 3814 Ashburton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James P Luttrell

6 DATE OF BIRTH (month, day, and year) Aug 15, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Samuel Hobgood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Francis S Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant James P Luttrell
(Address) 3814 Ashburton ave

15 Filed OCT 14 1920 19... ROBERT B KRAUSE (Registrar)

Burial Permit (Deputy)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-12 1920

17 I HEREBY CERTIFY, That I attended deceased from July, 1920, to Oct 12, 1920, that I last saw h. alive on Oct 12, 1920, and that death occurred, on the date stated above, at 2.20 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Chronic Nephritis (interstitial)

Nephritis (duration) several yrs. ? mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical only

(Signed) Henry Luttrell, M. D.

, 19 (Address) 3902 Groveland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Oct 14 1920
20 UNDERTAKER	ADDRESS
W M Routson	2235 W Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D47281

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47281

CERTIFICATE OF DEATH.

68

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3501 Fairview ave ST.; 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary K. Rogers

(Residence in Baltimore: No. 3501 Fairview av St.; 44 yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Sept (Month) 19 (Day), 1875 (Year)

7-AGE, 55 yrs. — mos. 22 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School teacher
(b) General nature of industry, business, or establishment in which employed (or employer). Public Sch

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Joseph Rogers.

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Mary E Bowen

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Rogers.

(Address) 3501 Fairview Ave

15- ROBERT B KRAUTER

Filed OCT 14 1920, 191.... Burial Permit ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 29 1919, to Oct. 17 1920, that I saw h... alive on Oct. 17 1920, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia Coma

Chronic Nephritis

(Duration) ....yrs....mos....da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs....mos....da.

(Signed) H. Labotz Groth M. D.

Oct. 14, 1920 (Address) 905 N. Eden St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL, Oct. 18, 1920

20-UNDERTAKER H. C. Hagel

ADDRESS 17 N Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D47282

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47282

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital H.S.P.G. ST.: 29 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincen Hughes

(Residence in Baltimore: No. 6 Glenwood Ave St.; 69 yrs., 7 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH, March 16, 1925
(Month) (Day) (Year)

7-AGE, 69 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: retired plumber
(b) General nature of industry, business, or establishment in which employed (or employer): plumber 059

9-BIRTHPLACE, (State or Country), Balt. Md

PARENTS.

10-NAME OF FATHER, John Hughes

11-BIRTHPLACE OF FATHER (State or Country), Balt. Md.

12-MAIDEN NAME OF MOTHER Unknown (?)

13-BIRTHPLACE OF MOTHER (State or Country), Balt. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia B. Holman

(Address) Johns Hopkins Balt

15- OCT 14 1920 ROBERT B. KNAUTER

Filed ....., 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 22 1920, to Oct 12 1920, that I saw him alive on Oct 12 1920, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

4 days

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis and Femoral thrombosis

(Duration) yrs. mos. 7 ds.

(Signed) F B Hohman M. D.

Oct 13, 1920 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 20 dy. In the State 69 yrs. mos. ds.

Where was disease contracted, if not at place of death? unknown

Former or usual residence 6 Glenwood ave. Balt. Md

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Oct 15, 1920

20-UNDERTAKER A O Hughes

ADDRESS 17 S Broadway

M 1625

D47283

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47283

CERTIFICATE OF DEATH.

X175 D47283

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. Mercy Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Otto Wesley Hutton

(~~Residence~~ in Baltimore: No. Garrison & Belvd Md St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, October (Month) 16th (Day) 1837 (Year)

7-AGE, 82 yrs. 11 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Gardner
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Co Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Mayfast

(Address) 1313 E Federal st

15-

Filed ....., 191 ROBERT B KRAUTER Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 12 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Femur
Direct cause Accident (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Shock (Duration) 1 yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner)

191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Stone Chapel M E Cemetery	Oct 15th 1917
20-UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 47284 HEALTH DEPARTMENT—CITY OF BALTIMORE 169 D 47284

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Baltimore Harbor ST. V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francisco Margarette

(Residence in Baltimore: No. 718 E Broadway St.: 10. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Unknown, 1892.
(Month) (Day) (Year)

7-AGE, 28 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Fireman
(b) General nature of industry, business, or establishment in which employed (or employer). 076

8-BIRTHPLACE, (State or Country). Spain

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Caslen Valeo Station

(Address) Bank st

15- OCT 14 1920 Filed ....., 191.... ROBERT S. BRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 7, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquisition (Inquest, autopsy or inquiry.) find that said deceased came to Accidental death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thomas J. Kinsella (Coroner) M. D.

Oct 14 1920 (Address) 1500 Eden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Carmel Cemetery	Oct. 14., 1920
20-UNDERTAKER H Vander Voo	ADDRESS 1710 Fleet St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47285 — gD47285

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin E. Pafel

(a) RESIDENCE. No. 3417 E. Fairmount ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 11 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 25 - 1919

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
—	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Albert Pafel

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Hammer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Albert Pafel
(Address) 3417 E. Fairmount Ave

15 Filed OCT 14 1920 19 ROBERT P. LEE Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1920, to Oct 14, 1920, that I last saw him alive on Oct 14, 1920, and that death occurred, on the date stated above, at 1:40 a.m.

The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) None (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Positive diphtheria culture

(Signed) B. Macgowan M. D.

Oct 14 1920 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Oct 14 1920
20 UNDERTAKER	ADDRESS
H. Gonder & Son	1710 Eat St

INSTRUCTIONS: Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047286

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1047286

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 341 So 12 St.: 26 Ward)

REGISTERED NO. 120

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Miller.

(a) RESIDENCE. No. 341 So 12 St. St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. X mos. X ds. How long in U. S., if of foreign birth? 65 yrs. X mos. X ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Miller

6 DATE OF BIRTH (month, day, and year): April 24 1840

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: X Feldpusch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry Miller.
(Address) 341 So 12 St.

15 Filed OCT 14 1920 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 12 1920

17 I HEREBY CERTIFY, That I attended deceased from August 15, 1920, to Oct. 12, 1920, that I last saw her alive on Oct 11, 1920, and that death occurred, on the date stated above, at 3.15 A m.

The CAUSE OF DEATH* was as follows:

Exhaustion
Acute Uraemia

(duration) 1 yrs. X mos. 3 ds.

CONTRIBUTORY (Secondary): Senile Debility

(duration) X yrs. 6 mos. X ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Same

(Signed) Jas L. Duncan, M. D.

1013 19 (Address) 248 So 3d St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Oct 14 1920
20 UNDERTAKER: Philip Herrig	ADDRESS 2016 Aisquith

N. B.—WRITE PLAINLY, WITH UNFADING INK—PENCIL WRITING CANNOT BE READ. AGE should be stated EXACTLY. PHYSICIANS should be careful in filling out this certificate. Information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Interstitial Nephritis

Dan Funk

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47287 HEALTH DEPARTMENT—CITY OF BALTIMORE D47287

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 746 N. Lexington ST.; 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Pollnow

(a) RESIDENCE. No. 746 N. Lexington St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred not known yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a ~~H married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Theodore Pollnow

6 DATE OF BIRTH (month, day, and year) Nov 18 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER Charles Muller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Rev O Mantbach

(Address) 746 N Lexington St

15 Filed OCT 14 1920 ROBERT [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 12 1920

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1920, to Oct 12, 1920,

that I last saw her alive on Oct 11, 1920,

and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Old age

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) old age

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) How Hemmeter, M. D.

, 19 (Address) 800 Harlem Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Violetsville	Oct 16 1920
20 UNDERTAKER	ADDRESS
Mrs Chas A. J. Rohde	600 Arlington Ave

IMPORTANT.—NAME AND AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-2-19—H. P. Co.—1000 Bks.

1047288

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047288

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1359 Andre. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Monroe.

(a) RESIDENCE. NO. 1359 Andre ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Monroe

6 DATE OF BIRTH (month, day, and year) Oct. 22. 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Shea

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Wiel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Harry Monroe (Address) 1359 Andre.

15 Filed OCT 14 1920 ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12 1920

17

I HEREBY CERTIFY, That I attended deceased from July 19, 1920, to Oct 12, 1920, that I last saw h[illegible] alive on Oct. 12, 1920, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the liver.

(duration) [illegible] yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Wm. T. Seabury, M. D.

10/13, 1920 (Address) 638 Fairfax Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	10/14 1920
20 UNDERTAKER	ADDRESS
Ed B Hale	115 E Mt St

I. B. P. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-11—M. & T.—2000 Blks.

D.47289

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47289

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.) 209 Belair Rd ST.; 26 (WARD)

Ruxpebury

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William M Neary

(Residence in Baltimore: No. 209 Belair Ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH: Oct (Month) 27 (Day) 1870 (Year)

7-AGE: 50 yrs. 1 mos. 9 da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired 086
(b) General nature of industry, business, or establishment in which employed (or employer): Hotel Keeper

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Neary

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Ceth Fowler

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm D Corse

(Address) Gardenville Md

15-

Filed ....., 191.....

OCT 14 1920

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Oct (Month) 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1920, to Oct 17 1920, that I saw h[illegible]ive on Oct 17 1920, and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

.....

.....

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Valvular disease heart

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Wm D Corse M. D.

Oct 13, 1920 (Address) Gardenville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery — DATE OF BURIAL, Oct 16, 1920

20-UNDERTAKER Keith Lassahn & Sons — ADDRESS Fullerton Md.

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47290

D.47290

HEALTH DEPARTMENT—CITY OF BALTIMORE

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Allison

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records, (Address) New City Hospital

15 Filed 10/11/19 20 Robert P. Harrison, Registrar

18 OCT 14 1920 Burial Permit Clerk 17568

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 10 1920

17 I HEREBY CERTIFY, That I attended deceased from August 26, 1919, to October 10, 1920, that I last saw her alive on October 9, 1920, and that death occurred, on the date stated above, at 7:00 A.m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed) J. Bateman, M. D.

10/11/19 20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	19
20 UNDERTAKER	ADDRESS
Wm. F. Wiegand	OCT 14 1920

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47291 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47291

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital St. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Toadvine

(a) RESIDENCE. No. Unknown St., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1821

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	99			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital

15 Filed OCT 14 1920 19 [Robert P. Harrison, Registrar]

[Burial Permit Clerk]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 9 1920

17 I HEREBY CERTIFY, That I attended deceased from November 7, 1919, to October 9, 1920, that I last saw her alive on October 8, 1920, and that death occurred, on the date stated above, at 4:00 A. m.

The CAUSE OF DEATH* was as follows:

Arterio - sclerosis
(No cerebral hemorrhage.)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic bronchitis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No special test.

(Signed) W. S. Stevenson, M. D.

(Address) New City Hospital. 10/9/1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND.	OCT 14 1920
20 UNDERTAKER Commissioner Health.	ADDRESS

OCT 14 1920

Bar. Wm. E. WOODALL

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D.47292 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47292

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 S. 13th St. St. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Howard Gregory.

(a) RESIDENCE. No. 627 S. 13th St. ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 13-1920

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City. Md.

PARENTS

10 NAME OF FATHER Howard E. Gregory

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto! Md.

12 MAIDEN NAME OF MOTHER Anna Burns 10/14/20

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Howard E. Gregory
(Address) 627 S. 13th St.

15 Filed OCT 14 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 14-, 1920, to Oct 14-, 20.

that I last saw h... alive on ..., 19...

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. W. Harrison, M. D.

(Address) 719 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Oct. 16 1920
20 UNDERTAKER Lilly and Zeile	ADDRESS 402 S Mo

mation should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.47293 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47293

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 619 N Decker ave St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie A Kintop

(Residence in Baltimore: No. 619 N Decker Ave St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Oct 13 (Month) (Day), 1900 (Year)

7-AGE,	If LESS than 1 day,
20 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Herman Kintop

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Ellie Gabrecht

13-BIRTHPLACE OF MOTHER (State or Country), South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie Kintop

(Address) 619 Decker Ave.

15- Robert P. Harrison,

Filed OCT 14 1920, 191 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 14 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Oct 12 1920, that I saw h[illegible] alive on Oct 12 1920, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arthritis

(Duration) yrs. 3 mos. ds.

(Signed) H Murray Gray M. D.

Oct 14, 1920 (Address) 1545 McCulloh St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Fifth Reform Cemetery — DATE OF BURIAL, Oct 15 1920

20-UNDERTAKER, Jas L Miller — ADDRESS 2334 Jefferson St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1047294 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047294

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED No. C 120

CITY OF BALTIMORE (No. 400 S. Hanover St. Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Ann Huggins

(Residence in Baltimore: No. 400 S. Hanover st. St.: 60 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Feb. (Month) 28 (Day), 1824 (Year)

7 AGE: 96 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Allegheny Co. Md.

PARENTS

10 NAME OF FATHER: Jerard Clay

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Rebecca Naddell

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hamelme Huggins

(Address) 400 S. Hanover St.

15 Filed OCT 15 1920 BOBERT B KRAUTH Registrar of Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 14th (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jany, 1917 to Oct 14th 1920 that I saw her alive on Oct 10th 1920 and that death occurred, on the date stated above, at 3.05 Am.

The CAUSE OF DEATH* was as follows:

Complication diseases
(Heart, Lungs & Kidneys
involved (Duration) Yrs. 5 yrs. mos. ds.

Contributory (SECONDARY) Pulmonary Edema (Duration) about 24 hrs. mos. ds.,

(Signed) Howard D Lewis M. D.

Oct 14, 1920 (Address) 38 W. 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Green Mount DATE OF BURIAL: Oct 15, 1920

20 UNDERTAKER: John O. Mitchell ADDRESS: 1201 W. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047295 HEALTH DEPARTMENT—CITY OF BALTIMORE 047295

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. ____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 909 Valley ST. 10 WARD)

2-FULL NAME Domenican Pompilli

(a) RESIDENCE. NO. 909 Valley ST., WARD. ____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ~ mos. ds. How long in U. S., if of foreign birth? 15 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~ (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Ottorio Pompilli

6 DATE OF BIRTH (month, day, and year) 9/2/1881

7 AGE 39 Years — Months 1 — Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS
10 NAME OF FATHER Fraweses Onorato
11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy
12 MAIDEN NAME OF MOTHER Rose. Castiglia
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant Ottavio Pompilli
(Address) 909- Valley st

15 Filed OCT 15 1920, 19 ____ ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to Oct. 13, 1920, that I last saw her alive on Oct 10th 1920, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) ____ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? no Date of ____

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Eugene L. Jennings M. D.

Oct. 14, 1920 (Address) 2314 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL 10/15/20 19

20 UNDERTAKER: George J. Ruth — ADDRESS 1735 Hanford.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047296

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047296

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1403 N. Eden ST.: 5 WARD)

2-FULL NAME Florence Brown

(a) RESIDENCE. No. 1403 Asked Alley ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married Widow

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) born in Baltimore City

PARENTS

10 NAME OF FATHER Simon Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) born in Md

12 MAIDEN NAME OF MOTHER Annie Dugler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) born in Md

14 Informant Mr Annie Johnson

(Address) 1403 Asken Alley

15 Filed Oct 15 19 [illegible] Registrar

OCT 15 1920

Burial Permit Olerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19— , 1920, to Oct. 13, 1920, that I last saw h[illegible] alive on Oct. 13, 1920, and that death occurred, on the date stated above, at 1:30 p- m.

The CAUSE OF DEATH* was as follows:

Phthisis pulmonalis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. A. Johnson M. D.

19 (Address) 1532 Monument E

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Oct 16 1920
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	Ashburton Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47297 HEALTH DEPARTMENT—CITY OF BALTIMORE D47297

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 129

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Meddoy

(a) RESIDENCE. No. 1724 Maryland Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18 1877

7 AGE 43 Years 4 Months 25 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country) but in the City 15 Years

PARENTS

10 NAME OF F[illegible] Lewis Tillman

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Delia Wilson

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Hospital Record (Address) J. H. H.

15 Filed , 19 ROBERT B. ARMSTRONG Registrar

OCT 15 1920 Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13th 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 12th, 1920, to Oct 13th, 1920, that I last saw her alive on Oct 13th, 1920, and that death occurred, on the date stated above, at 12 06 p.m.

The CAUSE OF DEATH* was as follows:

Post Operative Shock

(duration) yrs. 1 mos. 1 hr

CONTRIBUTORY (Secondary) Myomata Uteri Infected

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 13, 20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Leo Brady, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Oct. 16. 1920

20 UNDERTAKER Mrs Robert A. Elliott — ADDRESS 1725 Fahland Ave

mation should be carefully supplied. Avoid [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Kirstein

D47298 HEALTH DEPARTMENT—CITY OF BALTIMORE D47298

64

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME Mrs. Sarah Kirstein

(Residence in Baltimore: No. 1723 Jefferson St.; 28 yrs., ... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH. Unknown (Month) — (Day), 1870 (Year)

7-AGE. 50 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Russian

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis

(Address) 1411 E Baltimore St

15- Otto Kraeuter

OCT 15 1920 ROBERT H KRAUTER

Filed....., 191.... Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 14th. (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 8th. 1920, to Oct. 14th 1920, that I saw her alive on Oct. 14th. 1920, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolus

..... (Duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B. Sachs M. D.

10/14, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 6 ds. In the State 25 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 1723 Jefferson St

19-PLACE OF BURIAL, OR REMOVAL. Hebrew Rodeph Shalom — DATE OF BURIAL, 10-15, 1920.

20-UNDERTAKER Jack Louis — ADDRESS 1411 E Balto

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

1047299 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047299

CERTIFICATE OF DEATH.

REGISTERED NO. C 3 48

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument St.; ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Bessie Caplan

(Residence in Baltimore: No. 1515 E. Pratt St St.; 17 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, Unknown, 1860 (Month) (Day) (Year)

7-AGE. 60 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jesse's Son Caplan

(Address) 1411 E Balt St

15- OCT 15 1920 ROBERT F KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 14th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1) 1920, to Oct 14, 1920, that I saw her alive on Oct 14 1920, and that death occurred, on the date stated above, at 7:32 p m.

The CAUSE OF DEATH* was as follows:

Arthritis Deformans

(Duration) 15 yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) General Senility

(Duration) yrs. 2 mos. ds.

(Signed) Charles S. Levy M. D.

10-14, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 25 ds. In the State 17 yrs. — mos. — ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 1515 E Pratt St

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery — DATE OF BURIAL, 10-15, 1920

20-UNDERTAKER Jack Levin — ADDRESS 1411 E Balt St

N. B.—EVERY item of information should be given, and every statement made as full and explicit as possible, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D47300 HEALTH DEPARTMENT—CITY OF BALTIMORE D47300

D47300

CERTIFICATE OF DEATH.

REGISTERED NO. C 119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1306 N. Strieker ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kate West

(Residence in Baltimore: No. 1306 N. Strieker St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown, 1861.
(Month) (Day) (Year)

7-AGE 59 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Reuben Whiting

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Esther Lancaster

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Esther M. West

(Address) 1306 N. Strieker St

15- Filed OCT 15 1920, 191 ROBERT B. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 12th, 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25th 1920, to Oct 11th 1920, that I saw her alive on Oct 11 1920, and that death occurred, on the date stated above, at 2A m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Acute Gastritis

(Duration) yrs. mos. 20 ds.

(Signed) Harry G Brown, M. D.

Oct 13, 1920 (Address) 1501 Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Oct 15, 1920.

20-UNDERTAKER Samuel G Hensley — ADDRESS 378 W Biddle

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1447301

HEALTH DEPARTMENT—CITY OF BALTIMORE

1447301

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 573 S. Linwood Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George T. Lecompte

(a) RESIDENCE. No. 513 S. Linwood Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Lecompte

6 DATE OF BIRTH (month, day, and year) June 15 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 6 yrs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Lecompte

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Betty Evens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Margaret Lecompte

(Address) 513 S. Linwood Ave

15 Filed OCT 15 1920 ROBERT P. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 18th, 1920, to Oct 11th, 1920, that I last saw him alive on Oct 11th, 1920, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Bowels.
& Dysentery

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod, M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 15 1920
20 UNDERTAKER H. Sander Sons	ADDRESS 1110 Park Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047302 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047302

CERTIFICATE OF DEATH.

REGISTERED NO. 77

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Vondeheid—

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1839—

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81—			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records.
(Address) New City Hospital.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13, 1920

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1914 to October 13, 1920, that I last saw her alive on October 13, 1920, and that death occurred, on the date stated above, at 11:05 P.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis
(no cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed) R. Hermann M. D.

10-14-20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Oct 15 1920
20 UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson Ave

OCT 15 1920 DEATH PERMIT ISSUED

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPA-
at it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
s on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D47303 HEALTH DEPARTMENT—CITY OF BALTIMORE 8-91 D47303

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 Parish ST.; 16 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Leonard

(Residence in Baltimore: No. 913 Parish St. ST.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Col'd	Child

6-DATE OF BIRTH, Aug 14 (Month) (Day) 1908 (Year)

7-AGE,	If LESS than 1 day,
....yrs. 3 mos. ....ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 800

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, James Leonard

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Mary Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Johnson

(Address) 913 Parrish St.

15- OCT 15 1920 ROBERT B KRAUTER

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 14 (Month) (Day), 1912 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1912, to Oct 13 1912, that I saw h[illegible] alive on Oct 12 1912, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(Duration) ....yrs. 1 mos. ....ds.

(Signed) W. T. Coleman M. D.

Oct 14, 191 2 (Address) 2137 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Oct 15 1912

20-UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

0947304 HEALTH DEPARTMENT—CITY OF BALTIMORE 0947304

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 72 annapolis ave ST.; Mt Winans WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Savage

(Residence in Baltimore: No. 72 annapolis ave St.; 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	Colo	Widower

6-DATE OF BIRTH, about ....., 1 ..... (Month) (Day) (Year)

7-AGE, 64 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer 140
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Savage

(Address) 72 e Annapolis ave

15- Filed OCT 15 1920, 191.....

ROBERT P KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 14 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10 12 1920, to 10 13 1920, that I saw him alive on 10 13 1920, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J.B. Hall M. D.

10.14.1920 (Address) Halethorpe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Oct 15, 1920
20-UNDERTAKER JAMES H. DENNIS	ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

047305 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 047305

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 407 N Fremont Ave) (STREET) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norma D Smith

(Residence in Baltimore: No. 407 N Fremont Ave St.) yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, July 22 (Month) (Day), 1920 (Year)

7-AGE.	If LESS than 1 day,
yrs. 2 mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country). Balto md

PARENTS.

10-NAME OF FATHER. William Smith

11-BIRTHPLACE OF FATHER (State or Country). Baltimore md

12-MAIDEN NAME OF MOTHER. Mildred Bell

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mildred Smith

(Address) 407 N Fremont st

15- Filed OCT 15 1920 191 ROBERT I KRAUTER Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 13 (Day), 1920 (Year)

I HEREBY CERTIFY, That I attended deceased from Oct 12 1920, to Oct 13 1920, that I saw her alive on Oct 13 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Bronchitical Pneumonia

(Duration) yrs. 3 mos. ds.

(Signed) John Carter M. D.

(Address) 1911 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Oct 15th, 1920

20-UNDERTAKER	ADDRESS
Joseph A Farrell	2318 Pinkney

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of CAUSE OF DEATH is important. See instructions on back of certificate.

Spec.—5-12-13—M. & T.—500 Bks.

2047306 HEALTH DEPARTMENT—CITY OF BALTIMORE 2047306

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2nd & Chesapeake Ave ST.; Brooklyn 2nd WARD) REGISTERED NO. C 25 7

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Myrtle Eleanor Johnson

(Residence in Baltimore: No. 2nd & Chesapeake Ave St.; Brooklyn Md 1 yrs., 5 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, April 26, 1917
(Month) (Day) (Year)

7-AGE, 2 yrs. 5 mos. 18 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none 000
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Brooklyn Md

PARENTS.

10-NAME OF FATHER, Herbert Johnson

11-BIRTHPLACE OF FATHER (State or Country), Balto Co Md

12-MAIDEN NAME OF MOTHER, Myrtle Remmey

13-BIRTHPLACE OF MOTHER (State or Country), Brookly Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert Johnson

(Address) 2nd & Chesapeake Ave

15-

Filed OCT 15 1920 191... ROBERT J. KRAUSE Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 14th, 1920
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from October 1st 1920, to October 14th 1920, that I saw her alive on October 2nd 1920, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(Duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) — yrs. — mos. 1½ ds.

(Signed) Harry Weidler M. D.

Oct 15, 1920. (Address) 324 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery — DATE OF BURIAL, Oct 15, 1920

20-UNDERTAKER John F Denny — ADDRESS 715 Light st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47307

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D47307

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 240 S Albemarle ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Ferri

(a) RESIDENCE. NO. 240 Albemarle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt.
(State or country)

PARENTS

10 NAME OF FATHER Dominick Ferri

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Rumbina

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Dominick Ferri
(Address) 240 Albemarle

15 Filed OCT 15 1920 Registrar

Buried [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1920

17 I HEREBY CERTIFY, That I attended deceased from 10/1/20, 19, to 10/14/20, 19, that I last saw him alive on 10/13/20, 19, and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis 00N

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H W Fadden, M. D.

19 (Address) 321 E 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent Cemetery	Oct 16 1920
20 UNDERTAKER	ADDRESS
Wendell Dippel & Son	378 N

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

847308 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

103 847308

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 304 Albemarle ST.: 3 WARD)

2-FULL NAME Salvatore Renena

(Residence in Baltimore: No. 304 Albemarle St.: 27 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, August (Month) 25 (Day), 1879 (Year)

7-AGE, 41 yrs. 1 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cement Worker
(b) General nature of industry, business, or establishment in which employed (or employer)..... O & S

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Joseph Renena

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Emila Renena

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Renena

(Address) 304 Albemarle St

15-

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 13 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) investigation find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

about 4 hours (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otwin Lynn Smith M. D. (Coroner)

10/15, 192.. (Address) 100 W Lombard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Vincent Cemetery | DATE OF BURIAL, Oct 16, 1920

20-UNDERTAKER Ronald Pearson | ADDRESS 82 S Pa

BOREY'S LEADER

OCT 15 1920

Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47309

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47309

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. 2619 St Paul ST.; 17 WARD)

2-FULL NAME Emily Virginia Jones

(a) RESIDENCE. No. 2619 St Paul ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bennett Jones

6 DATE OF BIRTH (month, day, and year): May 15 1848

7 AGE — Years: 72 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Centreville Md

PARENTS

10 NAME OF FATHER: Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Comegys

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: W H Walden

(Address) 2619 St Paul

15 Filed OCT 15 1920 19 ROBERT B BRAUER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug ..... 19 19 to Oct 13 ..... 19 20 that I last saw h er alive on Oct 12 ..... 19 20 and that death occurred, on the date stated above, at 6-30 P. m.

The CAUSE OF DEATH* was as follows:

Arteris - Sclerosis

About (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy 2nd attack (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Lain M. D.

Oct 19 20 (Address) 12 E 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Middleburg Carroll Co Md

DATE OF BURIAL: Oct 16 1920

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

D. 47310 HEALTH DEPARTMENT—CITY OF BALTIMORE 2247310

CERTIFICATE OF DEATH.

167 REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ~~Hd Hopkins Hosp~~ 6 ST.; WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Bender

(Residence in Baltimore: No. 127 n Streeper St.)

3 yrs., 5 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Bale,

6-DATE OF BIRTH, May 3, 1916
(Month) (Day) (Year)

7-AGE, 3 yrs. 5 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Jos. Benda

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Ella Novotny

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. Benda

(Address) 127 N Streeper St

15- Robert P. Harrison,

Filed ..... 191.....

Burial Permit Clerk. — Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 13, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns about body & face

Marasmus
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. Stanley M. D.
(Coroner)

11-14, 1920 (Address) 408 001

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Oct 16, 1920

20-UNDERTAKER, Grant Enoch & Son — ADDRESS 1906 Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 15 1920

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47311 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47311

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Preston & Valley Sts. ST.: 10 WARD)

2-FULL NAME Mary Grill.

(a) RESIDENCE. No. Little Sisters of the Poor ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 40 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow of

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Grice.

6 DATE OF BIRTH (month, day, and year): 1843

7 AGE: Years 77 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: John Stockhaus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Sister Florence.

(Address): Preston & Valley Sts.

15 Filed ..... 19 .....

Registrar

OCT 15 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 14 1920

17 I HEREBY CERTIFY, That I attended deceased from No record, 19..., to ..., 19...,

that I last saw h[illegible] alive on Oct 13, 1920,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

Influenza (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Warren, M. D.

Oct 14/20 19 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Oct 16 1920

20 UNDERTAKER: Frank Crockson — ADDRESS: 1906 Ashland

MARRIED SHOULD BE STATED LAST. GIVE FULL NAME. NAME OF HUSBAND, WIFE, PARENT, SHOULD STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47312

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47312

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 Lancaster ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Barylska

(Residence in Baltimore: No. 1707 Lancaster St.; 29 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH Sept. 14, 1862 (Month) (Day) (Year)

7-AGE, 58 yrs. 1 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Work
(b) General nature of industry, business, or establishment in which employed (or employer)..... 137

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Josef Zielinski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Anne Szreinska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Barylski

(Address) 1707 Lancaster St.

15-

Filed ....., 191.....

Robert P. Harrison,
Registrar.

OCT 15 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 14, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 15 1920, to October 14 1920, that I saw her alive on October 14 1920, and that death occurred, on the date stated above, at 3.40 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchitis

..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) H. Swarbrick M. D.

14-10-, 1920 (Address) 782 S. Ann st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Oct. 16, 1920

20-UNDERTAKER John M. Weber — ADDRESS 1803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47313

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47313

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2815 Simpson Al ST.; 9 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Cole

(a) RESIDENCE. No. 2815 Simpson Al ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.M	aa	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of x

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 2 min.
	x	x	x	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ud 000

(b) General nature of industry, business, or establishment in which employed (or employer) no

(c) Name of employer no

9 BIRTHPLACE (city or town) 2815 Simpson
(State or country) Balto Maryland

PARENTS

10 NAME OF FATHER Peter Cole

11 BIRTHPLACE OF FATHER (city or town) va
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Eliz Morrison

13 BIRTHPLACE OF MOTHER (city or town) va
(State or country) Virginia

14 Informant
(Address)

15 Filed ....., 19 Robert P. Harrison, Registrar

OCT 15 1920

Burial Permit Clerk.

12570

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1920, to Oct 14, 1920, that I last saw h alive on Oct 14, 1920, and that death occurred, on the date stated above, at 5.10 a.m.

The CAUSE OF DEATH* was as follows:

premature Birth and
physical condition of
the mother

x (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) physical condition of Mother (duration) x yrs. 7 mos. 0 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Ed Stull, M. D.

19 (Address) 426 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

20 UNDERTAKER — ADDRESS

OCT 15 1920

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47314

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47314

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 232 N Kennd ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Bryan

(a) RESIDENCE. No. 232 N Kennd ST.. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ellen Bryan

6 DATE OF BIRTH (month, day, and year) Oct 7 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Dent Kerr

11 BIRTHPLACE OF FATHER (city or town) (State or country) U

12 MAIDEN NAME OF MOTHER U

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U

14 Informant Mrs Frank Zimmerman
(Address) 5132 N Kennd

15 Filed OCT 15 1920 16 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-17 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1920, to Oct 17, 1920, that I last saw h[illegible] alive on Oct 17, 1920, and that death occurred, on the date stated above, at 5-10 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Bay View Asylum
Cooken Av.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. L. Meyer Jr, M. D.

10/19 1920 (Address) 1638 E Balto. St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL Oct 16 1920

20 UNDERTAKER Wm Cook

ADDRESS Balto Md

Spec.—5-19-13—M. & T.—500 Bks.

20.47315

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.47315

CERTIFICATE OF DEATH.

134

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 421 Winston Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen B. Eckart

(Residence in Baltimore: No. 421 Winston Ave St.: 16 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: October 2, 1905 (Month) (Day) (Year)

7-AGE: 25 yrs. mos. 13 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Hartford Co., Md

PARENTS.

10-NAME OF FATHER: Thomas H. Stallman

11-BIRTHPLACE OF FATHER (State or Country): Balto. Md.

12-MAIDEN NAME OF MOTHER: Frances V Baldwin

13-BIRTHPLACE OF MOTHER (State or Country): Hartford Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Ferdinand F Eckart

(Address): 421 E. Winston Ave

15-

Filed ..... 191.....

Registrar.

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 15 (Day) 15, 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 4 1920, to October 15 1920, that I saw her alive on October 14 1920, and that death occurred, on the date stated above, at 3 A.m.

The CAUSE OF DEATH* was as follows:

Miscarriage - November 24, 1919.
May 30 1920 - Chronic Pelvic Cellulitis - Osteomyelitis: June 1 1920 Laparotomy - Drainage.
June 15, 1920 Tuberculosis of Anal - (Duration) yrs. 4 mos. 15 ds.

CONTRIBUTORY (Secondary) Septicemia

..... (Duration) yrs. mos. 4 ds.

(Signed) G. D. T. Bishop M. D.

Oct 15, 1920 (Address) 501 Shefield Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 7 mos. ds. In the State 16 yrs mos. ds.

Where was disease contracted, if not at place of death? Place of death

Former or usual residence Same

19-PLACE OF BURIAL OR REMOVAL: Presbyterian Grave

DATE OF BURIAL: Oct. 15, 1920

20-UNDERTAKER: Wm. Cook

ADDRESS: 502 E Mitchell Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITIONS very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.47316 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47316

CERTIFICATE OF DEATH. 43V

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 Rose ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lena Shipley

(a) RESIDENCE. No. 1307 Rose ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred. G. Shipley

6 DATE OF BIRTH (month, day, and year) Nov 11, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto - Md.

PARENTS

10 NAME OF FATHER Fred Liebert.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Lena Liebert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown.

14 Informant Husband.
(Address) 1307 Rose St.

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1920, to Oct. 14, 1920; that I last saw her alive on Oct. 14, 1920, and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) secondary anemia

× Cachexia (duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of June 10, 1920

Was there an autopsy? no

What test confirmed diagnosis? Micro. section

(Signed) F. A. Holden, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Oct 18 1920
20 UNDERTAKER William Cook	ADDRESS 5025 Hart Ln

OCT 19 1920 Robert F. Harrison, Local Registrar

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47317 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47317

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1622 E. Biddle ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alphonso B. Schuchts

(a) RESIDENCE. No. 1622 E. Biddle ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annette L. Schuchts

6 DATE OF BIRTH (month, day, and year) Jan. 22—1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician 079

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer C & C Phone Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER David Schuchts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary D. Corpren

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore,

14 Informant David Schuchts

(Address) 1622 E. Biddle St.

15 Filed OCT 15 1920 19

Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1920, to Oct 14, 1920, that I last saw h... alive on Oct 14, 1920, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 107 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	10/18" 1920
20 UNDERTAKER	ADDRESS
Chas. P. Evans & Son	115 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47318 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47318

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 N. Bethel ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie Menke

(a) RESIDENCE. NO. 1608 N. Bethel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 11 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of William Menke

6 DATE OF BIRTH (month, day, and year) Nov. 10th 1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Bernhard Schmuck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Menke (Address) 1608 N. Bethel St.

15 Filed OCT 15 1920, 19 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14th 1920

17

I HEREBY CERTIFY, That I attended deceased from November 1919, to Oct 14, 1920, that I last saw her alive on Oct 14, 1920, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Phthisis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam. of sputum

(Signed) C. E. Carman, M. D.

10-14 1920 (Address) 1707 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct. 16th 1920
20 UNDERTAKER	ADDRESS
Mr & Mrs. John H. Teufel	80 N. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47319 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 47319

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Columbia Ave St. 21st WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Marie Mathews

(a) RESIDENCE. No. 706 Columbia Ave St. 21st WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced (or) WIFE of Frank V. Mathews

6 DATE OF BIRTH (month, day, and year) Feb. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Cumberland Md.

PARENTS

10 NAME OF FATHER Earnst Trautman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Berg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Albert Mathews
(Address) 706 Columbia ave

15 Filed OCT 15 1920 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14th 1920

17 I HEREBY CERTIFY, That I attended deceased from September, 1918, to Oct 14th 1918, that I last saw her alive on Oct 11th 1920, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Neptritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. F. Courtney, M. D.

10/14/ 1920 (Address) 654 Columbia ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	Oct. 16 1920
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Eighth St.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47320

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47320

CERTIFICATE OF DEATH.

79-091

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Lakeland, Baltimore Co. ST. 23 WARD)

2-FULL NAME Margaret Shea.

(a) RESIDENCE. NO. 1232 S. Sharp ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 11 mos. 17 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Oct 26 1911

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	8	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Shea

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine Donlon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Catherine Shea

(Address) 1232 S. Sharp St

Filed OCT 15 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1920, to Oct 13, 1920, that I last saw h alive on Oct 13, 1920, and that death occurred, on the date stated above, at 8 20 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? 1232. S Sharp St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thomas Wheeler M. D.

(Address) Lakeland, Balto Co.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cem.	Oct 16 1920
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Infection prior.

Spec.—6-9-19—H. P. Co.— 1000 Blks.

D.47321 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47321

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 E Fort ave St. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Malone

(a) RESIDENCE. NO. 1608 E. Fort ave ST., 24 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Malone

6 DATE OF BIRTH (month, day, and year) May 1841

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 60

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queens County Ireland

PARENTS

10 NAME OF FATHER Patrick Casey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Queens Co. Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Joseph Malone (Address) 1608 E. Fort ave.

15 Filed OCT 15 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1920, to Oct 12, 1920, that I last saw her alive on Oct 12, 1920, and that death occurred, on the date stated above, at 6 PM m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(durstion) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J. M. Lipsky, M. D.

10/13 1920 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Harford Rd.	Oct. 16 20

20 UNDERTAKER Margaret G. Flynn ADDRESS 1732 Light St.

D.47322 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47322

CERTIFICATE OF DEATH.

289

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1538 S. Charles St. St.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary S. Moran.

(Residence in Baltimore: No. 1538 S. Charles St. St.: 39 yrs., 11 mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White.	Single.

6-DATE OF BIRTH, November 6 th. 1880, (Month) 1 (Day) (Year)

7-AGE, 39 yrs. 11 mos. 8 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None. 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Thomas Moran.

11-BIRTHPLACE OF FATHER (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER Mary F. Barrett.

13-BIRTHPLACE OF MOTHER (State or Country). Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Moran. (father)

(Address) 1538 S. Charles St.

15-

Filed ....., 191.....

OCT 15 1920 Robert F. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 14th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration).....yrs.....mos.....ds.

(Signed) H. McKenhardt M. D.
(Coroner)

Oct. 15th 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem.	Oct. 16, 1920

20-UNDERTAKER Margaret E. Flynn

ADDRESS 1422 Light St.

N. B. Every question must be answered. If unknown, say so. Where a number is required, as in case of children, the exact number of days, hours or minutes should be stated. Ages must be carefully supplied. AGE must be entered in every case, and it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 47323 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 47323

1721

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3849 Roland Ave. ST. 13 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha E. Boublitz

(Residence in Baltimore: No. 3853 Roland Ave. St. 37 yrs., — mos. — ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, ... Aug. (Month) 1 (Day), 1841 (Year)

7-AGE, 79 yrs. 2 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country). Balto. Co. Md.

PARENTS.

10-NAME OF FATHER, Charles Marsh

11-BIRTHPLACE OF FATHER (State or Country) Balto. Co. Md.

12-MAIDEN NAME OF MOTHER Elizabeth Fromer

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry H. Boublitz

(Address) 3640 Hickory Ave

15-

Filed OCT 15 1920, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 13 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, Autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Fracture of skull caused by falling down stairs

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Koerner M. D.
(Coroner)

Oct 16 1920 (Address) 3532 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Lorraine Cemetery	Oct. 16, 1920
20-UNDERTAKER	ADDRESS
Horace Burgee Son	3631 Falls Rd.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47324 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47324

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3 ~ Buchland Av ST.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel J Phelan

(a) RESIDENCE. No. 3 ~ Buchland ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year) Nov 11 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ship Fitter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Daniel J. Phelan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Mary F Sinclair

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Daniel J. Phelan

(Address) 3 Buchland Ave Balto

15 Filed OCT 15 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/13/2019

17 I HEREBY CERTIFY, That I attended deceased from May 1 19 19 to Oct 13 19 19

that I last saw h alive on Oct 1 19 20.

and that death occurred, on the date stated above, at 11 PM m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. Bacilli

(Signed) [illegible], M. D.

19 (Address) 4316 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem. Co	10/16/2019
20 UNDERTAKER George J Pfeiffer	ADDRESS 1735 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Care and accuracy in giving information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47325 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47325

81

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1639 Hilton ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Rebecca Dennis

(a) RESIDENCE. No. 1639 Hilton ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm A Dennis

6 DATE OF BIRTH (month, day, and year) Sept 10 1829

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	91	1	5	

8 OCCUPATION OF DECEASED 000

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co Md

PARENTS

10 NAME OF FATHER Thos Harman

11 BIRTHPLACE OF FATHER (city or town) Anne Arundel Co (State or country) Md

12 MAIDEN NAME OF MOTHER Micah Pilley

13 BIRTHPLACE OF MOTHER (city or town) Anne Arundel Co (State or country) Md

14 Informant (Address) Mrs Egon Milton Dennis 1634 Hilton St

15 Filed OCT 15 1920 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15, 1920

17 I HEREBY CERTIFY, That I attended deceased from October 8, 1920, to October 15, 1920, that I last saw her alive on October 15, 1920, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Maurice E. Shannon, M. D.

19 (Address) 3300 W. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ordon Hill	Oct 19 19 20
20 UNDERTAKER	ADDRESS
W. L. Sudworth & Son	Home

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47326 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47326

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3376 North Ave ST.: 12 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Albert Ridgley

(Residence in Baltimore: No. 331 E. North Ave St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, January 17th, 1908
(Month) (Day) (Year)

7-AGE, 12 yrs. 9 mos. 24 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, Albert D. Ridgley

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Orilla A. Smith

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert D. Ridgley

(Address) 331 E. North Ave

15-

Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk
Registrar.

OCT 15 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 13th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 6th 1920, to Oct 13th 1920, that I saw h... alive on Oct 13th 1920 and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo. W. Harrington M. D.

Oct 13th, 1920 (Address) 401 E. 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Oct. 16 1920
20-UNDERTAKER W. J. Tuckwiller	ADDRESS Bath

IMPORTANT. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47327 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47327

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 3309 Windsor Mill Rd. St.; 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dr Albert N Smith

(Residence in Baltimore: No. 3309 Windsor Mill Rd St.; 3 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Male	White	

6-DATE OF BIRTH, July (Month) 26 (Day), 1837 (Year)

7-AGE, 83 yrs. 4 mos. 6 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dentist
(b) General nature of industry, business, or establishment in which employed (or employer): 15

9-BIRTHPLACE, (State or Country), N. Y.

PARENTS.

10-NAME OF FATHER, Geo Smith

11-BIRTHPLACE OF FATHER (State or Country), N Y

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. A. Smith

(Address) 3309 Windsor Mill Rd.

15- Robert P. Harrison,

Filed OCT 16 1920, 191.... Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 15 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1918, to Oct 16 1920, that I saw him alive on Oct 15 1920, and that death occurred, on the date stated above, at 9 15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. D. Logue M. D.

10/16/20, 191... (Address) 2094 Bdway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Hauck's Hill	Oct 18, 1920
20-UNDERTAKER Geo W. Lewis	ADDRESS 531 Fremont

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47328

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47328

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 933 N. Broadway ~~St.~~ 7 WARD)

2-FULL NAME Amanda E. Peterman

(a) RESIDENCE. NO. 933 N. Broadway ~~St.~~ 7 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Peterman

6 DATE OF BIRTH (month, day, and year) May 6, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Peterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Alice Kirkendall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Williamsport Pa

14 Informant Dr Emily Peterson
(Address) York Rd

15 Filed ... 19 ... Registrar

OCT 16 1920

Robert F. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1920. to Oct. 14, 1920. that I last saw h~~e~~ alive on Oct. 14, 1920. and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute indigestion

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby, M. D.

(Address) 1223 N. Caroline st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hisor Cemetery.	Oct 17 1920
20 UNDERTAKER	ADDRESS
John Herring & Co	2008 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.47329 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47329

CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 E. Hamburg ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Dent

(a) RESIDENCE. No. 421 E. Hamburg ST., 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John R. Dent

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant ...

(Address) 421 E Hamburg St

15 Filed OCT 16 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1920, to Oct 14, 1920, that I last saw h[illegible] alive on Oct 14, 1920, and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach.

(duration) 1 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Operated on Aug 27/19

(Signed) M. L. Dechtenberg, M. D.

10/15/1920 (Address) 1224 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 19
20 UNDERTAKER	ADDRESS
Wm J. McDermott Sons	1424 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47330 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47330

CERTIFICATE OF DEATH. 39

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1612 So Charles ST. 23 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Cassidy

(Residence in Baltimore: No. 1612 So Charles St.; ....yrs., ...mos. ....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, April 6 (Month) (Day), 1851 (Year)

7-AGE, 69 yrs. 6 mos. 15 da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Saloon 040
(b) General nature of industry, business, or establishment in which employed (or employer): Bar Keeper

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, William

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Williams

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Cassidy

(Address) 1612 S. Charles St.

15-

OCT 16 1920

Filed....., 191....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 13 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 20 1920, to Oct 13 1920, that I saw h[illegible] alive on Oct 13 1920, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

Asthenia

(Duration) ....yrs. ....mos. 3 da.

CONTRIBUTORY (Secondary) Cancer of Liver

(Duration) 1 yrs. 2 mos. ....da.

(Signed) J. F. Harrison M. D.

Oct 16, 1920. (Address) 16 Randall

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, New Cathedral

DATE OF BURIAL, Oct 15, 1920

20-UNDERTAKER Mrs J. E. Greenlaw

ADDRESS 1415 E Lex

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47331 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47331

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 Wilcox ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Annie Lyons

(a) RESIDENCE. NO. 1205 Wilcox ST., WARD. 10

(Usual place of abode) (If absent, give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? 49 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Lyons

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co. Md.
(State or country) Not Known

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant Mr. John Lyons
(Address) 1205 Wilcox St

15 Filed OCT 16 1920 1920 Robert P. Harrison. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15th 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1920, to Oct 14, 1920, that I last saw h e alive on Oct 14 20 19 , and (that death occurred, on the date stated above, at 11 45 a. m.

The CAUSE OF DEATH* was as follows:

OVER

Arterio Sclerosis Heart Disease

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Robinson, M. D.

19 (Address) 247 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct 18 1920
20 UNDERTAKER	ADDRESS
Cosey Brock & Son	1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47332

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47332

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 843 Lafayette Av) (WARD) 17

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Hughes

(Residence in Baltimore: No. 744 Lafayette St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct 15th, 1920 (Month) (Day) (Year)

7-AGE, ... yrs. ... mos. ... ds. If LESS than 1 day, 10 hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... ~ ... 00
(b) General nature of industry, business, or establishment in which employed (or employer) ... ~

9-BIRTHPLACE, (State or Country), 843 Lafayette Av

PARENTS.

10-NAME OF FATHER, Howard Hughes

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Annie Thomas

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Hughes

(Address) 843 Lafayette Av

15-

Filed OCT 16 1920, 191...

Robert P. Harrison,
Burial Permit Clerk.
Registrar.

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 16th, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 1920, to Oct 16th 1920, that I saw h[er] alive on Oct 16th 1920, and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Hydramnios cy Mother
1. Premature Birth

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) A. Lee Ebe M. D.

(Date) 10/16, 1920 (Address) 927 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Mont Auburn

DATE OF BURIAL, Oct. 16, 1920

20-UNDERTAKER John F. Owens

ADDRESS 532 Walbrook

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47333 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47333

CERTIFICATE OF DEATH. 43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 W. Belvedere Ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Despeaux

(a) RESIDENCE. No. 115 W. Belvedere ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Harry P. Despeaux

6 DATE OF BIRTH (month, day, and year) June 11-72

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 03

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Henry Bumm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry P. Despeaux (Address) 318 W. Belvedere

15 Filed OCT 16 1920 Robert P. Harrison Registrar
(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) Oct 13 1920

17

I HEREBY CERTIFY, That I attended deceased from Apr. 20, 1920, to Oct. 13, 1920, that I last saw h er alive on Aug. 1/20, and that death occurred, on the date stated above, at 7 55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) — yrs. 10 mos. — ds.

CONTRIBUTORY (Secondary) General carcinosis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Yes Date of Apr. 30/20

Was there an autopsy? No

What test confirmed diagnosis? Study of tumor.

(Signed) Alexius McGlannan, M. D.

, 19 (Address) 1157 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Oct 16 1920
20 UNDERTAKER Philip Hennig	ADDRESS 2456 Orleans

TION is very important. See instructions on back of certificates.

D.47334

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D.47334

28

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 318 S. Bouldin St. St. 26 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Frieda Dora Baker.

(Residence in Baltimore: No. 318 S. Bouldin St. St. 22 yrs. 3 mos. 20 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Single

6 DATE OF BIRTH: June (Month) 24, (Day) 1898 (Year)

7 AGE: 22 yrs. 3 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Can inspector- Can
(b) General nature of industry, business, or establishment in which employed (or employer): Factory

9 BIRTHPLACE (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: William J. Baker.

11 BIRTHPLACE OF FATHER (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Frieda Ricker,

13 BIRTHPLACE OF MOTHER (State or country): Germany.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sophia Baker,

(Address) 318 S. Bouldin St.

15. Filed. OCT 16 1920, 191 Robert P. Harrison, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 14, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 1, 1920 to October 14 1920 that I saw her alive on October 14, 1920 and that death occurred, on the date stated above, at 9 P. m. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration) ..... yrs. 18 mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen C. Beetham, M. D.

10-15-1920 (Address) 3139 E. Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Trinity Cem.	Oct 17, 1920
20 UNDERTAKER: Philip Herwig	ADDRESS 2016 Orleans St

Spec —5-19-13—M. & T.—500 Bks.

20.47335

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.47335

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3414 Norwood Ave. ST.; 15 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Carrick.

(Residence in Baltimore: No. 3414 Norwood Ave. St.; 60 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, October 9, 1841. (Month) (Day) / (Year)

7-AGE, 79 yrs. mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired. 088
(b) General nature of industry, business, or establishment in which employed (or employer): Police Department.

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Amos Carrick.

11-BIRTHPLACE OF FATHER (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER Susannah Downes.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rida M. Carrick,

(Address) 3414 Norwood Ave.

15-

Filed OCT 16 1920, 191

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 14, 1920. (Month) (Day) , 191 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 17, 1920 191, to Oct. 14, 1920. 191, that I saw Him alive on Oct. 13, 1920. 191, and that death occurred, on the date stated above, at 7.40A m.

The CAUSE OF DEATH* was as follows:

Senile Arterio-sclerosis

(Duration) About 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage.

(Duration) yrs. mos. 3 ds.

(Signed) C. W. Schilling, M. D.

Oct. 14, 1920. (Address) 4107 Liberty Hghts.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dulaney's DATE OF BURIAL, Oct. 16, 1920

20-UNDERTAKER John Oddenhall & N. Laporte ADDRESS

Important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D.47336 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47336

CERTIFICATE OF DEATH.

8-91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 E. York ST. 22 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Sidorchuk

(Residence in Baltimore: No. 7 E. York st. St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Oct. 12, 1914 (Month) (Day) (Year)

7-AGE, 1 yrs. ... mos. 4 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... 000
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Dennid Sidorchuk

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER M. Arena

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dennis Sidorchuk

(Address) 7 York St.

15-

Filed OCT 16 1920, 191...

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 16, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1920, to Oct. 14 1920, that I saw him alive on Oct 14, 1920, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Jno. M. Lwoche M. D.

Oct. 16, 1920. (Address) 2352 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Oct. 18, 1920

20-UNDERTAKER John Gravinowski ADDRESS 425 S. Paca St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47337

CERTIFICATE OF DEATH.

80 D47337

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2206 Ruskin Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Uhlfelder.

(a) RESIDENCE. No. 2206 Ruskin Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mayer Uhlfelder

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Mecklenburg
(State or country) Germany

PARENTS

10 NAME OF FATHER Samuel Lachmann

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mayer Uhlfelder
(Address) 2206 Ruskin Ave

15 Filed OCT 16 1920, 19 Robert P. Harrison Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16. 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14. 1920, to date of death
that I last saw him alive on Oct. 16 1920,
and that death occurred, on the date stated above, at 5 A. m.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Irving Landis, M. D.

19 (Address) 824 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harsimus Cem	Oct 18 1920
20 UNDERTAKER	ADDRESS
J. Ahrens & Co	1611 Mad Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47338

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47338

151

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 W. Lanvale St.: 12 WARD)

2-FULL NAME Baby Sullivan

(a) RESIDENCE. NO. 8 W. Lanvale St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wh	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of x

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1920	Oct	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nil 800

(b) General nature of industry, business, or establishment in which employed (or employer) Nil

(c) Name of employer Nil

9 BIRTHPLACE (city or town) 8 W Lanvale St

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Dan Sullivan

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) U.S.A.

12 MAIDEN NAME OF MOTHER Mamie Lee Wilson

13 BIRTHPLACE OF MOTHER (city or town) Va.

(State or country) U.S.A.

14 Informant D. Sullivan Father

(Address) 8 W Lanvale St

15 Filed OCT 16 1920 16 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/15/20 19

17

I HEREBY CERTIFY, That I attended deceased from Oct 15, 1920, to Oct 15, 1920, that I last saw him alive on Oct 15, 1920, and that death occurred, on the date stated above, at 7.20 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth and Physical condition Like Parents

x (duration) x yrs. 7 mos. 1 ds.

CONTRIBUTORY (Secondary) Physical condition of Mother (duration) x yrs. 7 mos. 1 ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Myer I Hall M. D.

19 (Address) 1426 E. 20 St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL.	19
20 UNDERTAKER	ADDRESS OCT 16 1920

TION is very important. See instructions on back of certificates.

D.47339 HEALTH DEPARTMENT---CITY OF BALTIMORE D.47339

CERTIFICATE OF DEATH

14

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 327 Belvedere ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Rogers

(Residence in Baltimore: No. 327 Belvedere Ave St.; 2 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6-DATE OF BIRTH Sept (Month) 18 (Day), 1872 (Year)

7-AGE 48 yrs. — mos. 27 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Carpet Cleaning
(b) General nature of industry, business, or establishment in which employed (or employer): Co

9-BIRTHPLACE (State or country): N.Y.

PARENTS

10-NAME OF FATHER: John Rogers

11-BIRTHPLACE OF FATHER (State or country): N.Y.

12-MAIDEN NAME OF MOTHER: Elizabeth —

13-BIRTHPLACE OF MOTHER (State or country): N.Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Viola B Rogers

(Address) 327 Belvedere ave

15- Robert P. Harrison,

OCT 16 1920 Filed ..... 191 Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 10 (Month) 15 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9-[illegible], 191..., to, 10-15-20, 191..., that I saw h... alive on 10-15-20, 191..., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Aortic " and
Obstruction

(Duration) 8 yrs 10 mos ..... ds.

Contributory (SECONDARY) Dysentery

(Duration) ..... yrs ..... mos ..... ds.

(Signed), Henry Russell M. D.

10-16-20, 191... [Address] 3702 Gracelan

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Sandy Mount Cemetery Md.

DATE OF BURIAL: Oct 18, 1920.

20-UNDERTAKER: H. N. Routson

ADDRESS: 2238 N North ave

state CAUSE OF DEATH in plain terms, so that it may be properly classi... Exact statement of OCCUPA...
TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Yeides

47340 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓47340

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. St. Vincents Infant Asylum 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabelle Yeides

(a) RESIDENCE. No. St. Vincents Infant Asyl. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 24 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none ✓✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Nettie Yeides

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant S. W. Matthews
(Address) St. Vincents Infant Asyl.

15 Filed OCT 17 1920 ROBERT P. BEAUFER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1920, to Oct. 15, 1920, that I last saw h[illegible] alive on Oct 14, 1920, and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Ileo-colitis

(duration) yrs. 2 mos. 21 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 2 mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas & Claudius, M. D.

(Address) 504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Oct 16 192[illegible]

20 UNDERTAKER ADDRESS

C. W. Bailey & Sons 1827 W. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1047341

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047341

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 W. Lexington St.; 19 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Jane Alley

(Residence in Baltimore: No. 1316 W. Lexington St.; 0 yrs. 16 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec. 30, 1865
(Month) (Day) (Year)

7-AGE, 54 yrs. 2 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 037
(a) Trade, profession, or particular kind of work: Horse
(b) General nature of industry, business, or establishment in which employed (or employer): Auction

9-BIRTHPLACE, (State or Country), New Jersey

PARENTS.

10-NAME OF FATHER, Geo. W. Patterson

11-BIRTHPLACE OF FATHER (State or Country), New Jersey

12-MAIDEN NAME OF MOTHER Mary E. Shepherd

13-BIRTHPLACE OF MOTHER (State or Country), New Jersey

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alfred Z. Alley

(Address) 1316 W. Lexington St.

15- OCT 17 1920 ROBERT E KRAUTER
Filed....., 191.....
Registrar.

Burial Permit [illegible]

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 16, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 11 1920, to Oct. 16 1920, that I saw h[illegible] alive on Oct. 16 1920, and that death occurred, on the date stated above, at 1.10 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(Duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Asthenia & Septicemia

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. A. Thomas M. D.

10/16, 191.. (Address) 119 W. Eden Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Park N.J. DATE OF BURIAL, Oct. 19, 1920

20-UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette St.

Spec.—8-24-14—M. & T.—2000 Bks.

1947342 HEALTH DEPARTMENT—CITY OF BALTIMORE 1947342

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 Curtis Ave St.; 25 WARD) REGISTERED No. C 104

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paulina Kulcicky

(Residence in Baltimore: No. 919 Curtis Ave St.; Yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Dec (Month) 26 (Day), 1919 (Year)

7-AGE.	If LESS than 1 day,
yrs. 9 mos. 20 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md Balto.

PARENTS.

10-NAME OF FATHER, Peter Kulcicky

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Martha Kosh

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Kulcicky

(Address) 919 Curtis Ave

15-

Filed OCT 17 1920, 191

ROBERT B KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 30 1920, to Oct 14 1920, that I saw her alive on Oct 14 1920, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Leon L Hoke M. D.

Oct 17, 1920 (Address) Curtis Bay Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem. DATE OF BURIAL. Oct 18, 1920

20-UNDERTAKER Frank Cracknell ADDRESS 1906 Eutaw Pl

important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1047343 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047343

CERTIFICATE OF DEATH.

120

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 512 Runnsen ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Bertha Gage

(Residence in Baltimore: No. 512 Runnsen St.; 24 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, August 11, 1896
(Month) (Day) (Year)

7-AGE, 24 yrs. 2 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Kitchen Girl
(b) General nature of industry, business, or establishment in which employed (or employer): Hotel

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Louis Gage

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Laura Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary S. Carter

(Address) 512 Runnsen St.

15- OCT 17 1920 ROBERT B KRAUTER

Filed ....., 191.... Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Duodenum

Nephritis

(Duration) ....yrs. 4 mos. ....ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)

Oct. 14, 1920 (Address) 1302 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, W. J. Aulen Co's — DATE OF BURIAL, Oct 18, 1920

20-UNDERTAKER David Easton — ADDRESS 916 Fremont

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047344 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047344

CERTIFICATE OF DEATH. 285

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) New City Hospital, (St.:) 5 (Ward)

2-FULL NAME John Maisel = Minsel

(a) RESIDENCE. NO. 256 N. Exeter St. ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1/ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co., Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed OCT 17 1920 19 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 16 1920

17 I HEREBY CERTIFY, That I attended deceased from October 15, 1920, to October 16, 1920.

that I last saw him alive on October 15, 1920.

and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test.

(Signed) J. H. Norman, M. D.

10/16/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wella Cemetery	Oct 19 1920
20 UNDERTAKER William Cook	ADDRESS Fort North ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1047345 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047345

CERTIFICATE OF DEATH.

79 ✓ REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1147 Dexter ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Deever

(Residence in Baltimore: No. 1147 Dexter St.; 29 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Sept 13, 1875
(Month) (Day) (Year)

7-AGE, 45 yrs. 1 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John H Deems

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Laura V Tracey

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Cook

(Address) 1110 Ridgley St.

15- Filed OCT 17 1920, 191... ROBERT B KRAUTER Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 16, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5 1920, to Oct 14 1920, that I saw her alive on Oct 14 1920, and that death occurred, on the date stated above, at 8.30 P.m.

The CAUSE OF DEATH* was as follows:

Volvular Heart disease

..... (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Erysipelas of face

..... (Duration) ....yrs....mos....ds.

(Signed) Thos B Hall M. D.

....., 191... (Address) Hollins St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem — DATE OF BURIAL, Oct 17, 1920

20-UNDERTAKER William Cook — ADDRESS 602 E North ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47346 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D47346

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospital St.: 4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Deters

(a) RESIDENCE. No. 1131 Light St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced (write the word)~~
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10-15-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto —
(State or country)

PARENTS

10 NAME OF FATHER Henry Deters

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Delair

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Md.

14 Informant Hospital Record.
(Address)

15 Filed OCT 17 1920 ROBERT F. LEAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-15-1920

17 I HEREBY CERTIFY, That I attended deceased from 10-5, 1920, to 10-15, 1920, that I last saw h. im alive on 10-15, 1920, and that death occurred, on the date stated above, at 5-40 P. m.

The CAUSE OF DEATH* was as follows:
Premature Birth. (5 mo. dead)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Zeb. V. Hooper, M. D.

, 19 (Address) Univ. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem Co	Oct 16 1920
20 UNDERTAKER	**ADDRESS**
E & B Hurley	116 E Lexington St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

0947347 HEALTH DEPARTMENT—CITY OF BALTIMORE 0947347

CERTIFICATE OF DEATH.

91-126

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 941 N Broadway ST.;] WARD)

2-FULL NAME Dr. Francis A. Sauer

(a) RESIDENCE. No. 941 N Broadway ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L Sauer

6 DATE OF BIRTH (month, day, and year) Dec. 7 1845

7 AGE Years	Months	Days	10 If LESS than 1 day, ...hrs. or min.
74	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Doctor 054

(b) General nature of industry, business, or establishment in which employed (or employer) By Profession

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Sauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Celia Sauer (Address) 941 N Broadway

15 Filed OCT 17 1920 ROBERT B BRAUER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 5 1920 to Oct 15 1920

that I last saw him alive on Oct 14. 1920

and that death occurred, on the date stated above, at 7 30 AM

The CAUSE OF DEATH* was as follows:

Hypertrophied prostate-mic[illegible] tonsil mic - chronic purulent cystitis terminal pneumonia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) duration 2 wks, fr [illegible] over (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? pneumonia 2 days

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F J. Kirby M. D.

19 (Address) 110 S Fronte Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct 18 1920
20 UNDERTAKER James Dignan & Son	ADDRESS 1001 Paca

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047348

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047348

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 1382

CITY OF BALTIMORE: (No.) 925 Brooks Lane (St.:) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ronie Kahn Hamburger

(a) RESIDENCE. (No.) 925 Brooks Lane (St.) (Ward.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Phillip Hamburger

6 DATE OF BIRTH (month, day, and year) Dec 13 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Indostry, business, or establishment in which employed (or employer) —

(c) Name of employer —

000

9 BIRTHPLACE (city or town) (State or country) Evansville, Indiana

PARENTS

10 NAME OF FATHER Solomon Kahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Clara Gumprich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria

14 Informant Louis P. Hamburger

(Address) 1207 Eutaw Place

15 Filed OCT 17 1920 ROBERT R. LEAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1920

17

I HEREBY CERTIFY, That I attended deceased from June, 1917, to Oct. 16, 1920,

that I last saw h.. alive on Oct 16, 1920,

and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis: Cerebral Hemiplegia (Duration: 1 week);

Senile Dementia - Symptoms of Arteriosclerosis (duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger, M. D.

Oct 14 1920 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	10/18 1920
20 UNDERTAKER	ADDRESS
David Sondheim	18 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47349 HEALTH DEPARTMENT—CITY OF BALTIMORE D47349

HS

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2223 Madison Ave ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gerson Miller

(a) RESIDENCE. No. 2223 Madison Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jacob Miller
(Address) 2422 Linden ave

15 Filed OCT 17 1920 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1920, to Oct. 14, 1920, that I last saw h[illegible] alive on Oct. 14, 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Ventriculi

8

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gralic Test. Fluoroscope

(Signed) S. Wolman, M. D.

, 19 (Address) 2444 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Blair Rd Cemet

DATE OF BURIAL Oct 17 1920

20 UNDERTAKER Max Levinson

ADDRESS 1127 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47350 D47350

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 36 [illegible] St. ST.: 13 WARD)

2-FULL NAME Julius Sebastian Joyner

(a) RESIDENCE. NO. 2219 Linden Ave ST., WARD. 13th

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced
HUSBAND of (or WIFE of) Mary B. Joyner

6 DATE OF BIRTH (month, day, and year) Dec 4, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town) Farmville
(State or country) V.C.

PARENTS

10 NAME OF FATHER Julius S. Joyner

11 BIRTHPLACE OF FATHER (city or town) Farmville
(State or country) V.C.

12 MAIDEN NAME OF MOTHER Alice Turnage

13 BIRTHPLACE OF MOTHER (city or town) Farmville
(State or country) V.C.

14 Informant Mary B. Joyner
(Address) 2219 Linden Ave

15 Filed OCT 17 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 16, 1920, to Oct 16, 1920, that I last saw h.. alive on Oct. 16, 1920, and that death occurred, on the date stated above, at 10.45 Am.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) 7 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Myer A Weinberg, M. D.

, 19 (Address) 1724 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Oct 19 1920
20 UNDERTAKER George J. Smith	ADDRESS 1000 Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D47351 HEALTH DEPARTMENT—CITY OF BALTIMORE D47351

CERTIFICATE OF DEATH. 162

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Josh Hospital St.: 3 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Silolino Giardinas

(Residence in Baltimore: No. 1014 Fawn St. St.: 3 yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Boy

6-DATE OF BIRTH, August 24, 1916.
(Month) (Day) (Year)

7-AGE, 4 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Hampton, N.H.

PARENTS.

10-NAME OF FATHER, Nicolas Giardina

11-BIRTHPLACE OF FATHER (State or Country). Italy

12-MAIDEN NAME OF MOTHER Elizabeth R. Barnard

13-BIRTHPLACE OF MOTHER (State or Country), Lincoln Me

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nicolas Giardina

(Address) 1014 Fawn St

15- OCT 18 1920 ROBERT B KRAUTER

Filed....., 191... Burial Permit Issued Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 15, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and by (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Burns. Scalded by
milk molds.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) M Dunlea, M. D.
(Coroner.)
10-12, 1920 (Address) U.S. Lent.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL St Mary's Cem. DATE OF BURIAL. Oct 18 1920

20-UNDERTAKER Randall Dispensary ADDRESS 3 W Saratoga St

CAUSE OF DEATH to be plainly written, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47352 HEALTH DEPARTMENT—CITY OF BALTIMORE D47352

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Robt Garrett Hosp 18 104V REGISTERED NO.....

CITY OF BALTIMORE: (No. 27 N. Carey ST.: ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Brocato

(a) RESIDENCE. NO. 809 W. Lexington ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) June 14 1920

7 AGE: Years — | Months 4 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Samuel Brocato

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Samuel Brocato. (Address) 809 W. Lexington St.

15 Filed OCT 18 1920 ROBERT I. GRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1920, to Oct 17, 1920

that I last saw her alive on Oct 16, 1920,

and that death occurred, on the date stated above, at 6 25 A.m.

The CAUSE OF DEATH* was as follows:

Intestinal Decomposition

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none except Stools

(Signed) [illegible] M. D.

Oct 17 1920 (Address) 27 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore.	Oct 19- 1920
20 UNDERTAKER William Cook	ADDRESS 502 E. North

CAUSE OF DEATH must be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D47353

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47353

CERTIFICATE OF DEATH.

REGISTERED NO. C 8 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 Rutland ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Bolton

(Residence in Baltimore: No. 1518 Rutland ave. St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	married

6-DATE OF BIRTH, Dont Know (Month) , 1 (Day) (Year)

7-AGE,	If LESS than 1 day,
76 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara L. Bolton

(Address) 1518 Rutland Ave

15- Filed OCT 18 1920, 191.. ROBERT E KRAUTER BUREAU FORMS Registrar

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 12th 1920, to October 16th 1920, that I saw him alive on October 16th 1920, and that death occurred, on the date stated above, at 12:50 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Gastro-enterostomy

(Duration) yrs. 2 mos. ds.

(Signed) Albert G Bingwald M. D.

10/17/.., 1920. (Address) 165 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. dr. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cemy	Oct. 20., 1920
20-UNDERTAKER Robt J Turner Jr	ADDRESS 1402 N Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

0473354 HEALTH DEPARTMENT—CITY OF BALTIMORE 0473354

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Haupt.

(a) RESIDENCE. NO. Johns Hopkins Hospital. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 10/14/20

7 AGE	Years	Months	Days	If LESS than 1 day, 23 hrs. or min.
	✓	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Eugene Haupt

11 BIRTHPLACE OF FATHER (city or town) ✓ (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Hartmann

13 BIRTHPLACE OF MOTHER (city or town) ✓ (State or country) Md.

14 Informant Dr. E. L. Stone (Address) Johns Hopkins Hospital.

15 Filed OCT 18 1920 ROBERT B. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/15 1920

17

I HEREBY CERTIFY, That I attended deceased from 10/14, 1920, to 10/15, 1920, that I last saw him alive on 10/15, 1920, and that death occurred, on the date stated above, at 7 11 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(8 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓ Not Known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) E. L. Stone, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Kamel	Oct 18 1920
20 UNDERTAKER	ADDRESS
Peter Nicolaus	2046 Eastern Ave

TION is very important. See instructions on back of certificates.

047355 HEALTH DEPARTMENT---CITY OF BALTIMORE 047355

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1529 Edmondson Ave St. 19 WARD)

2-FULL NAME Lyttleton C. Bandel Jr.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1529 Edmondson Ave. St.; 15 yrs. ..... mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6-DATE OF BIRTH Dec. (Month) 22 (Day), 1904 (Year)

7-AGE 15 yrs. 10 mos. ..... ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE (State or country) Maryland

PARENTS

10-NAME OF FATHER Lyttleton C. Bandel

11-BIRTHPLACE OF FATHER (State or country) Balto. Md.

12-MAIDEN NAME OF MOTHER Nina A. Graham

13-BIRTHPLACE OF MOTHER (State or country) Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lyttleton C. Bandel

(Address) 1529 Edmondson Ave

15 OCT 18 1920 Filed ....., 191.....

ROBERT B KRAUTER
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH October 17. (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15, 1920, to, October 17 1920, that I saw h[illegible] alive on October 17. 1920, and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

about 3 months
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) Pyaemia, Phlebitis & Embolism

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George H. Hartman M. D.

..... 191 ..... [Address] 2200 Mayfield Ave

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Druid Ridge	Oct 20, 1920
20-UNDERTAKER	ADDRESS
George J. Smith	1005 W Fayette St

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 47356

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47356

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5236 (Park Heights) (St.) (21) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME [redacted]attie G. Hynes

(a) RESIDENCE. No. 5236 Park Heights St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

2 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Hynes

6 DATE OF BIRTH (month, day, and year): June 14 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9 BIRTHPLACE (city or town) (State or country): Penn.

PARENTS

10 NAME OF FATHER: James Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Agnes Fleming

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Thos. Hynes. (Address) 5236 Park Heights Ave

15 Filed OCT 18 1920 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-16 1920

17 I HEREBY CERTIFY, That I attended deceased from 10-16 1920 to 10-16 1920 that I last saw h[illegible] alive on 10-16 1920 and that death occurred, on the date stated above, at 4.00 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

several (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Anaemia

(duration) 1-2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Can't know

Did an operation precede death? No Date of

Was there an autopsy? No Physical Exam.

What test confirmed diagnosis?

(Signed) Henry Russell M. D.

10-16 1920 (Address) 3902 Groveland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	10-19-1920
20 UNDERTAKER: Graham & Walker	ADDRESS: 1234 W. Lof Ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 47357

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47357

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1554 N. Bruce ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry F. Schmidt

(Residence in Baltimore: No. 1554 N. Bruce St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, April 24th, 1920 (Month) (Day) (Year)

7-AGE, ... yrs. 5 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... Not any
(b) General nature of industry, business, or establishment in which employed (or employer) ... None

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Carl W. Schmidt

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Petersen

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carl W. Schmidt

(Address) 1554 N. Bruce St

15-

OCT 18 1920

Filed ....., 191.....

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 16th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 5th 1920, to Oct 16th 1920, that I saw h im alive on Oct 16th 1920, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis

(Duration) ... yrs. ... mos. 13 ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Wm. A. Sullivan M. D.

10/16, 1920 (Address) 1701 W. Fulton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Woodlawn — DATE OF BURIAL, Oct. 18, 1920

20-UNDERTAKER Josiah Lyser — ADDRESS 1620 W North ave

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Hoerichs

D47358 HEALTH DEPARTMENT—CITY OF BALTIMORE D47358

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2504 Mc Henry St.; 20 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Fred. Hoerichs.

(Residence in Baltimore: No. 2504 Mc Henry St; St.; 71 yrs., 8 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Jan. 28, 1849.
(Month) (Day) (Year)

7-AGE, 71 yrs. 8 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Barber 004
(b) General nature of industry, business, or establishment in which employed (or employer) Retired

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Hoerichs

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Caroline Hoerichs

(Address) 2504 Mc Henry St.

15- OCT 18 1920 ROBERT B KRAUTER

Filed....., 191.. DEPUTY REGISTRAR Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1. 1920, to Oct 15, 1920, that I saw h[illegible] alive on Oct 15, 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Intracerebral Hemorrhage

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Softening of the Brain

(Duration) 1 yrs. 6 mos. ds.

(Signed) W. Wilson M. D.

10.16, 1920. (Address) 522 Holland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Farmer or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cemetery	Oct. 18, 1920

20-UNDERTAKER Geo. L. Schwab & Bro. ADDRESS 2101 Eutaw Ave

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D47359

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47359

CERTIFICATE OF DEATH.

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 512 N. Schroder ST.; 18 WARD)

2-FULL NAME Cornelius John Kane

(a) RESIDENCE. No. 512 N. Schroder ST., 18 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Kane

6 DATE OF BIRTH (month, day, and year) Sept 27 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police Official

(b) General nature of industry, business, or establishment in which employed (or employer) Tub-key

(c) Name of employer Police Dept.

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER Cornelius Kane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Connell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Clora Kane
(Address) 512 N. Schroder St.

15 Filed OCT 18 1920 ROBERT B KRAMER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 15 1919, to Oct 16 1920, that I last saw him alive on Oct 15 1920, and that death occurred, un the date stated above, at 2.45 a. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease
(Mitral insufficiency)
(duration) 1 yrs or longer

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. Buchanan M. D.

19 (Address) 1323 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bonnie Brae	10-19 1920

20 UNDERTAKER Henry C. Brannigan Sons ADDRESS 517 N. Schroder St

Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

Meades

1047360

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047360

CERTIFICATE OF DEATH.

REGISTERED NO. 15-151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1318 Vincent Street (St.) (Ward) 15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Meades

(a) RESIDENCE. No. 1318 Vincent Street St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. — ds. 0 How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) October 16, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or 0 min.
—	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore and
(State or country) Maryland

PARENTS

10 NAME OF FATHER Harry Meades

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Hattie Peters

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.

14 Informant Mother Hattie Peters
(Address) 1318 Vincent St.

15 Filed OCT 18 1920 Robert B. Krauter Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 16 1920

17 I HEREBY CERTIFY, That I attended deceased from October 16th, 1920, to October 16, 1920.

that I last saw her alive on October 16th, 1920.

and that death occurred, on the date stated above, at 9:30 A.m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Premature labor

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? not definite

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? none

(Signed) J. Morris Runge, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	OCT 16 1920
20 UNDERTAKER Commissioner Health.	ADDRESS

For Wm. R. Woodall

TION is very important. See instructions on back of certificates.

D47361 HEALTH DEPARTMENT—CITY OF BALTIMORE D47361

CERTIFICATE OF DEATH.

X 79

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Little Sisters of the Poor ST. 10 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Florence Jones.

(Residence in Baltimore: No. Preston & Valley St. St.; yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, 1845 (Month), 1 (Day), (Year)

7-AGE, 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. HW
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Middle Burg. Va

PARENTS.

10-NAME OF FATHER. Anthony Jones

11-BIRTHPLACE OF FATHER (State or Country), —

12-MAIDEN NAME OF MOTHER Mary Jones.

13-BIRTHPLACE OF MOTHER (State or Country), —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Florence

(Address) Preston & Valley Sts.

15. OCT 18 1920 ROBERT F KRAUTER
Filed, 191 Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 16, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. ds.

(Signed) J. Frank Jenkins M.D.
(Coroner)
Oct. 16 1920 (Address) 914 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence Virginia

19-PLACE OF BURIAL OR REMOVAL, Laurel — DATE OF BURIAL, Oct. 18, 1920

20-UNDERTAKER H. C. Niedefeld — ADDRESS 914 Fremont Ave

IMPORTANT. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bka.

D47362

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47362

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 738 Light ST.: 22 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Elizabeth Sauerhoff

(a) RESIDENCE. (Usual place of abode) NO. 738 Light ST.. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 609

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William P. Sauerhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Belvoir Md

12 MAIDEN NAME OF MOTHER Catherine Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Catherine Sauerhoff

(Address) 738 Light St

15 Filed OCT 18 1920 ROBERT I. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1919, to Oct 16, 1920, that I last saw h[illegible] alive on Oct 16, 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Brights Disease

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. B. White, M. D.

10/16, 1920 (Address) 12[illegible] Williams St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: CEDAR HILL. DATE OF BURIAL: OCT 19 1920

20 UNDERTAKER: JOHN F. DENNY ADDRESS: 715 LIGHT ST.

CAUSE OF DEATH to be plainly stated, so that it may be properly classified. EXACT statement of occupation of deceased is very important. See instructions on back of certificates.

D47363 HEALTH DEPARTMENT—CITY OF BALTIMORE D47363

CERTIFICATE OF DEATH.

56

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1124 Low ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Whitehill

(Residence in Baltimore: No. 1124 Low st. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Unknown (Month), 1 (Day), ... (Year)

7-AGE, 62 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Albert Whitehill

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Whitehill

(Address) 1124 Eden st

15- OCT 18 1920 Filed....., 191... ROBERT B KRAUTER Burial Permit (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 15 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon; and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) J. C. Dudley (Coroner.) M. D.

Oct. 18, 1920. (Address) 19 E. Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Returned Mt Carmel	Oct. 18, 19..
20-UNDERTAKER M. Lennon	ADDRESS 1107 Balto st

CASE OF DEATH in plain letters, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

0 47364

HEALTH DEPARTMENT—CITY OF BALTIMORE

0 47364

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 East ST.; 5 WARD) REGISTERED NO. C 91

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Geriusi

(Residence in Baltimore: No. 303 East St.; ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct (Month) 16 (Day), 1920 (Year)

7-AGE, ...yrs. ...mos. 2 ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Angelo Gerussi

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Maria Schillaci

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Angelo Gerussi

(Address) 303 East St

15- Filed OCT 18 1920, 191... ROBERT B KRAUTER Registrar.

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 18 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 17 1920, to Oct 18 1920, that I saw h... alive on Oct 17 1920, and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Extension

(Duration) ...yrs. ...mos. ...ds.

(Signed) Luigi D DiStefano M. D.

Oct 18 20, 191.. (Address) 407 N Exeter

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Vincent Cem

DATE OF BURIAL, 10/18/20, 191...

20-UNDERTAKER George J. Ruth.

ADDRESS 1735 Hyford ave

Important. See instructions on back of certificate.

D47365

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

68 175 D47365

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carter Gellison

(Residence in Baltimore: No. 1637 Fremont St.

St.; 13 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Color	Single

6-DATE OF BIRTH, Oct (Month) 18 (Day), 1882 (Year)

7-AGE,	If LESS than 1 day,
38 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Mingle Gellison

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Eva White

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mingle Gellison

(Address) 1414 Montgomery St (Father)

15-

Filed OCT 18 1920, 191 ROBERT E KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 14 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Injuries Probably Ruptured L. Kidney

(Duration) yrs. mos. 2 hrs ds.

CONTRIBUTORY (Secondary) Struck by auto truck

(Duration) yrs. mos. 2 hrs ds.

(Signed) W. H. Grossnickle M. D. (Coroner.)

10-16-, 1920 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Ch	Oct 19, 1920
20-UNDERTAKER	ADDRESS
H. A. Brown & Son	108 W. Monts

Please write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

847366

HEALTH DEPARTMENT—CITY OF BALTIMORE

847366

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 W Preston ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Blanche Hawkins

(Residence in Baltimore: No. 510 W Preston St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June 31 (Month) (Day), 1894 (Year)

7-AGE, 26 yrs. 8 mos. 16 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Normal Harris

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary Dyson

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Stores Aunt

(Address) 510 W Preston St.

15-

Filed OCT 18 1920, 191.....

ROBERT F KRAUTER
Burial Permit Issuing Officer.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 16th (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 9th 1920, to Oct 16th 1920, that I saw her alive on Oct 15th 1920, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Consumption

(Duration) about 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pr Consumption

(Duration) yrs. mos. ds.

(Signed) Samuel A Dan M. D.

Oct 17, 1920 (Address) 937 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery — DATE OF BURIAL, Oct. 19, 1920

20-UNDERTAKER W. M. Johnson — ADDRESS 1234 Etting St.

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.47367

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.47367

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3104 Fait ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Francis

(a) RESIDENCE. No. 3104 Fait ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced (or) ~~WIFE~~ Single

6 DATE OF BIRTH (month, day, and year) June 16, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co.

PARENTS

10 NAME OF FATHER Charles Francis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Canty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Dixon Francis
(Address) 3104 Fait ave

15 Filed ..... 19.....

CT 18 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 10th, 1920, to Oct 17th, 1920, that I last saw her alive on Oct 17th, 1920, and that death occurred, on the date stated above, at 11.45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) H. H. Schwatka, M. D.

10/17/1920 Address) 734 S Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cemetery	Oct 19 1920
20 UNDERTAKER Fiedler & Fiedler	ADDRESS 1739 Eager

CAUSES OF DEATH MUST BE PROPERLY DESCRIBED. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47368 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47368

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1852 N. Bay. ST.; 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Schatz

(a) RESIDENCE. NO. 1852 N. Bay ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Charles Henry Schatz

6 DATE OF BIRTH (month, day, and year) Jan. 2nd 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 900

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mr. Kohlbauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Anna B. Schatz

(Address) 1852 N. Bay St

15 Filed OCT 18 1920 By Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1920, to Oct 16, 1920, that I last saw her alive on Oct 15, 1920, and that death occurred, on the date stated above, at 10 20 P. m.

The CAUSE OF DEATH* was as follows:

Old Age -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding of Tub. Bacilli

(Signed) Wm J Watson, M. D.

Oct 17 1920 (Address) 2128 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct 20 1920
20 UNDERTAKER	ADDRESS
Henry Hoeck & Son	1301 E Eager

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47369 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47369

CERTIFICATE OF DEATH. X 176

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2320 Arunah Ave. ST.) (16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Orlando Burton

(a) RESIDENCE. No. 2320 Arunah St. WARD. Laurel Del.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Ellen Burton

6 DATE OF BIRTH (month, day, and year) April 18 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber 059

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Lee Hemmings Dec

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER John Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Emma McVey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant W. S. Evans

(Address) 2320 Arunah Ave

15 Filed OCT 18 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1920, to Oct 17, 1920, that I last saw him alive on Oct 16, 1920, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Pyelo-nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chr. Cystitis - hypertrophy of prostate (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary exam

(Signed) Arnold C. Gold, M. D.

12/17 1920 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Del	Oct 19 1920
20 UNDERTAKER	ADDRESS
W. T. Anderson	Laurel

CAUSE OF DEATH in plain terms, so that it may be understood by the laity. Do not use abbreviations or technical terms. Do not use words "Disease," "Cancer," "Tumor," "Cause unknown," or "Old age" alone. Do not report symptoms, but the disease causing them. Do not report mode of dying, such as "Heart failure," "Asphyxia," "Exhaustion," "Blood poisoning," "Septicemia," "Pyemia," "Uremia," "Coma," "Convulsions," or "Shock," unless it is clearly stated what disease caused these conditions. Operations, accidents, and injuries must be reported, with date of occurrence, and whether recovered from completely. Deaths from violence must be reported, stating means and nature of injury, and whether accidental, suicidal, or homicidal. Deaths during childbirth must be so reported, stating whether the fetus was viable or not. Deaths of infants must state whether premature or not, and number of hours lived. Deaths from contagious diseases must be reported at once by telephone. Deaths from tuberculosis must be reported on blanks furnished by the Department. Deaths from cancer must be reported on blanks furnished by the Department. Deaths from suspected criminal abortion must be reported on blanks furnished by the Department. Deaths from poisoning must be reported on blanks furnished by the Department. Deaths from drug addiction must be reported on blanks furnished by the Department. Deaths from alcoholism must be reported on blanks furnished by the Department. Deaths from suicide must be reported on blanks furnished by the Department. Deaths from homicide must be reported on blanks furnished by the Department. Deaths from accidental causes must be reported on blanks furnished by the Department. Deaths from natural causes must be reported on blanks furnished by the Department. Deaths from unknown causes must be reported on blanks furnished by the Department. Deaths from any other cause must be reported on blanks furnished by the Department.

CAUSE OF DEATH in plain terms, so that it may be understood by the laity. Do not use abbreviations or technical terms. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47370 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47370

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1229) N Bond ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ann McLaughlin

(Residence in Baltimore: No. 1229 N Bond St.; ....yrs.,....mos.,....ds.)

Was born 1850

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE~~ ~~MARRIED~~ WIDOWED, ~~DIVORCED~~ (Write the word.) widowed

6-DATE OF BIRTH, Sept 25th (Month), (Day), 1840 (Year)

7-AGE, 80 yrs. — mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susie McLaughlin

(Address) 1229 N. Bond St

15- Robert P. Harrison,

Filed OCT 18 1920, 191.... Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 20 1920, to Oct 16 1920, that I saw h— alive on Oct 14 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

.....

Carcinoma

..... (Duration) One yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) John F Avery M. D.

Oct 17, 1920 (Address) 1603 E Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem — DATE OF BURIAL, Oct 19, 1920

20-UNDERTAKER George J. Ruth — ADDRESS 1935 Hoffman

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.47371 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.47371

CERTIFICATE OF DEATH. 40

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Zorim Oliferruk

(a) RESIDENCE. No. 413 S. Durham St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: John Oliferruk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Hospital Records, (Address) New City Hospital.

15 Filed OCT 18 1920 16 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17, 1920

17 I HEREBY CERTIFY, That I attended deceased from October 14, 1920 to October 17, 1920, that I last saw h im alive on October 17, 1920, and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Unknown

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed) P. Herman M. D.

10-18-20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mathai cemetery	Oct 19 1920
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47372 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47372

CERTIFICATE OF DEATH.

9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2028 Eastern ave ST.; 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislawa Galab

(a) RESIDENCE. No. 2028 Eastern ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 30 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTAGE

10 NAME OF FATHER Stanislaus Galab

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Wiktorya Kalinowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stanislaus Galab
(Address) 2028 E Eastern ave

15 Filed OCT 18 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1920, to Oct 18, 1920, that I last saw h[illegible] alive on Oct 18, 1920, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

5 ds.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accidental Burns

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wellington J Rosenau M. D.

(Address) 807 N Kenwood Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 19 1920
20 UNDERTAKER	**ADDRESS**
John M Weber	1803 Bank St

TION is very Important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dr Edward Condon 750 W. Monument

D.47373

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 D.47373

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 E. 20th St.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Turner Graham

(a) RESIDENCE. NO. 321 E 20th St., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John F Graham

6 DATE OF BIRTH (month, day, and year): Oct 11 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 37

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Hannah Biddle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: John F. Graham

(Address) 321 E. 20th St

15 Filed OCT 18 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1920, to Oct 18, 1920, that I last saw h[illegible] alive on Oct. 17, 1920, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Vernon H. Condon, M. D.

Oct 18, 1920 (Address) 750 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friends Burying Ground

DATE OF BURIAL: Oct. 20 1920

20 UNDERTAKER: Wm Cook

ADDRESS: [illegible]

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks. Giacomo D'Amico

D.47374 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47374

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 232 S. Eden ST.; 3 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Giacomo D'Amico.

(Residence in Baltimore: No. 232 S. Eden St.; ....yrs., 2 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	White	Infant

6-DATE OF BIRTH, ... (Month) Sept. (Day) 16 (Year) 1920

7-AGE, ...yrs. 1 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, John D'Amico

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rose Calbo

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose D'Amico

(Address) 234 Eden St.

15- Filed OCT 18 1920, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 15 1920, to Oct 17 1920, that I saw him alive on Oct. 16, 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Congenital malformation of Heart.

..... (Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Eugene L. Pessagno M. D.

Oct. 18, 1920 (Address) 23 W. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Lorraine Park Cemetery	Oct 19, 1920
20-UNDERTAKER	ADDRESS
Lewis Bloom & Son	5 N. Howard St.

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.47375 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47375

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 N. Luzerne ST.; 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Emily Walter

(a) RESIDENCE. No. 217 N. Luzerne ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch. 24-1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at school

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Warren D. Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hicomico Co Maryland.

12 MAIDEN NAME OF MOTHER Annie J. Halfpenny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Warren D. Walter
(Address) 217 N. Luzerne ave

15 Filed OCT 18 1920 By Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-18 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 25. 1920. to Oct 18. 1920.
that I last saw h alive on " 17. 1920.
and that death occurred, on the date stated above, at 2:50a m.

The CAUSE OF DEATH* was as follows: Typhoid Fever

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Ocean city

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Death bed.

(Signed) A. C. Dean M. D.

10/18 1920 (Address) 2600 E Balto. St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Tyaskin, Hicomico Co Md	Oct 19 1920

20 UNDERTAKER H E Hughes ADDRESS 17 S Broadway

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D47376 HEALTH DEPARTMENT—CITY OF BALTIMORE D47376

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 W Lanvale ST.; 17 WARD) REGISTERED NO. C 44

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Gale

(Residence in Baltimore: No. 531 W Lanvale St.; 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 12, 1864
(Month) (Day) (Year)

7-AGE, 56 yrs. 7 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: General
(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Charles Coles

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Jannie Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Donncan Daughter

(Address) 232 N. Carlton

15- OCT 19 1920 ROBERT B KRAUTER
Filed....., 191.... Registrar.
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 16, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1920, to Oct 16 1920, that I saw h[illegible] alive on Oct 15 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcenoma of face

about (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(Duration) yrs. mos. 7 ds.

(Signed) Samuel A. T. Davis M. D.

Oct. 18, 1920 (Address) 939 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mont auburn	Oct. 19..., 1920
20-UNDERTAKER	ADDRESS
John R. Owens	538 N. Eutaw St

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047377

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047377

CERTIFICATE OF DEATH.

2679

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. City Hospitals, Bay View WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Brady

(a) RESIDENCE. NO. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) 1850.

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron-smith

(b) General nature of Industry, business, or establishment in which employed (or employer) 68th

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Conrad Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Records (Address) New City Hospital

15 Filed OCT 19 1920 ROBERT B KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16, 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 24, 1920, to Oct. 16, 1920, that I last saw him alive on Oct. 16, 1920, and that death occurred, on the date stated above, at 5-45 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? No especially

(Signed) [illegible], M. D.

Oct 17, 1920 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 19 1920
20 UNDERTAKER	ADDRESS
John Mitchell	120 W. Fayette St

TION is very important. See instructions on back of certificates.

John Williams

647378 HEALTH DEPARTMENT—CITY OF BALTIMORE 647378

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 691 W Mulberry St.: 4 WARD) REGISTERED No. C. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Williams

(Residence in Baltimore: No. 691 W Mulberry St St.: (yrs., 57 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	Colored	Single

6-DATE OF BIRTH, Dont Know, 18?0
(Month) (Day) (Year)

7-AGE, 30 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) U.R.&E. Co

9-BIRTHPLACE, (State or Country), Jamaica. West India

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Dicks

(Address) 691 W Mulberry St

15- Filed OCT 19 1920, 191... ROBERT B KRAUTER Registrar. Burial Permit Granted

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 17, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart (Duration) yrs. Dont Know mos. ds.

CONTRIBUTORY (Secondary) Dont Know I am, (Duration) yrs. mos. ds.

(Signed) H K Gorman M. D.
(Coroner.)

10-8-, 1920 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem'y	Oct 19, 1920
20-UNDERTAKER Mrs Robt A Elliott	ADDRESS 1726 Eastlander

CAUSE OF DEATH to plain terms, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificate.

D47379 HEALTH DEPARTMENT—CITY OF BALTIMORE D47379

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 561 Orchard St. 103

CITY OF BALTIMORE (No. Dora Johnson ST.: 17 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dora Johnson

(Residence in Baltimore: No. 561 Orchard St. St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	widow

6-DATE OF BIRTH, ... November 8, 1874
(Month) (Day) (Year)

7-AGE, 46 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home Duties
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Charles Hunkford

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Patsey Burwick

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henrietta Johnson

(Address) 217 W. Hoffman

15- Filed OCT 19 1920 191. ROBERT B KRAUTER BURIAL PERMIT CLERK Registrar.

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 18, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

5 Hours

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Indigestion (5 hrs)

(Duration) yrs. mos. ds.

(Signed) J. D. Kennedy M. D.
(Coroner.)

Oct 18, 1920 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt Lebanon	Oct 20 1920

20-UNDERTAKER	ADDRESS
Samuel T Hemsley	5720 Biddle

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47380 HEALTH DEPARTMENT—CITY OF BALTIMORE D47380

CERTIFICATE OF DEATH. 42

1-PLACE OF DEATH REGISTERED NO.....

CITY OF BALTIMORE: (No. Franklin Sq. Hospital St.. 18 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna Griffin

(a) RESIDENCE. No. 238 N. Appleton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jeremiah Griffin

6 DATE OF BIRTH (month, day, and year): 1889

7 AGE: Years 31 Months .. Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Martinsburg West Va

PARENTS

10 NAME OF FATHER: Albert Johnson
11 BIRTHPLACE OF FATHER (city or town) (State or country): West Va
12 MAIDEN NAME OF MOTHER: Emma Johnson
13 BIRTHPLACE OF MOTHER (city or town) (State or country): West Va

14 Informant: Jeremiah Griffin
(Address) 238 N Appleton

15 Filed OCT 18 1920 19 ROBERT P. PRUITT Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 16 1920

17 I HEREBY CERTIFY, That I attended deceased from October 11, 1920, to October 16, 1920, that I last saw her alive on Octo 16, 1920, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma Uter

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Octob 13-192

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings

(Signed) N. E. Lombard, M. D.

. 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Oct 19 19 20

20 UNDERTAKER: Samuel J Kenda — ADDRESS: N Bdle

(over)

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47381 HEALTH DEPARTMENT—CITY OF BALTIMORE D47381

29

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 E 24th St. ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry C Taylor

(a) RESIDENCE. No. 401 E 24th St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Taylor

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Church

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover Co Virginia

PARENTS

10 NAME OF FATHER Anderson Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hanover Co Va

12 MAIDEN NAME OF MOTHER Ann Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanover Co Va

14 Informant Mrs Alice Taylor
(Address) 401 E. 24th St

15 Filed OCT 19 1920 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) Oct. 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 1920, to Oct 19 1920, that I last saw h[illegible] alive on Oct 19 1920, and that death occurred, on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

? (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Unascertained

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical & Sputum

(Signed) Geo T Hall M. D.

, 19 (Address) 426 E 20th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 22 1920
20 UNDERTAKER	ADDRESS
Samuel T Lewis & Son	578 N Eden

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Rhodes

D47382

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47382

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 136 Richmond ST. 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margery Rhodes

(Residence in Baltimore: No. 136 Richmond St. 20 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct (Month) ..... (Day), 18[illegible] (Year)

7-AGE. 43 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). 70

9-BIRTHPLACE, (State or Country), Sigsbee N.C.

PARENTS.

10-NAME OF FATHER, Thomas Brewington

11-BIRTHPLACE OF FATHER (State or Country), Clinton N.C.

12-MAIDEN NAME OF MOTHER, Catharine Brewington

13-BIRTHPLACE OF MOTHER (State or Country), Clinton N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Luther Rhodes

(Address) 136 Richmond St.

15-

Filed OCT 19 1920 191.....

ROBERT B KRAUTER
BUREAU FIRM USE
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 15th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 18th 191 , to Oct 15th 1920, that I saw h[illegible] alive on Oct 15th 1920, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Thyroid Gland

(Duration) yrs. 3 mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John C. Stewart M. D.

10/19/1920 (Address) 704 W Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn

DATE OF BURIAL. Oct 19th, 1920

20-UNDERTAKER Samuel H Kemp

ADDRESS 578 N Eden

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

947383.

HEALTH DEPARTMENT—CITY OF BALTIMORE

947383.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 74

CITY OF BALTIMORE: (No. 850 W. 33rd ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace E. Jordon

(a) RESIDENCE. No. 850 W. 33rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Jordon

6 DATE OF BIRTH (month, day, and year) Nov. 28, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto; Md.

PARENTS

10 NAME OF FATHER Wm. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto; Md.

12 MAIDEN NAME OF MOTHER Mary Norwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto; Md.

14 Informant Mrs. Mary Baker
(Address) 850 W. 33rd St.

15 Filed OCT 19 1920 ROBERT E. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1920, to Oct. 18, 1920, that I last saw her alive on Oct. 17, 1920, and that death occurred, on the date stated above, at 8:45 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation, Chr. Endocarditis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) H. H. Marshall, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 20 19 20
20 UNDERTAKER	ADDRESS
H. S. Marshall	3539 Fall Rd

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47384 HEALTH DEPARTMENT—CITY OF BALTIMORE D47384

CERTIFICATE OF DEATH. 116

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isadore Fink

(a) RESIDENCE. No. 529 Cumberland ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Bessie Fink

6 DATE OF BIRTH (month, day, and year) October 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Postal Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Post Office

(c) Name of employer U. S. Government

9 BIRTHPLACE (city or town) (State or country) New York City N.Y.

PARENTS

10 NAME OF FATHER Solomon Fink

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Cecelia Fink

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J Lewis (Address) 1411 E Baltimore St

15 Filed OCT 19 1920, 19.. ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 19 1920

17 I HEREBY CERTIFY, That I attended deceased from October 12, 1920, to October 19, 1920, that I last saw him alive on October 19, 1920, and that death occurred, on the date stated above, at 5.20 P m.

The CAUSE OF DEATH* was as follows:

Abscess of Kidney

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of October 18, 1920

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W. H. Martin, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lehren Rosedale	10/19 1920
20 UNDERTAKER Jack Lewis	ADDRESS 1411 E Balt

TION is very important. See instructions on back of certificates.

D47385

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47385

CERTIFICATE OF DEATH.

167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Agnes Henderson

(Residence in Baltimore: No. 1333 Dupton St.

St.(yrs., 4 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, Don't Know (Month) (Day) 1916 (Year)

7-AGE, 4 yrs. 5 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, John W Henderson

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Daisy Rook

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W Henderson

(Address) 1333 Dupton St

15-

Filed OCT 19 1920, 191.... ROBERT J. BRAUTER Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns on body caused by accidentaly upsetting lamp (Duration) yrs. about 1/2 ds.

CONTRIBUTORY (Secondary) Accident

(Duration) yrs. mos. ds.

(Signed) W K Fowler M. D. (Coroner.)

10-18 1920 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Lancaster Co. Va.	Oct 20, 1920
20-UNDERTAKER	ADDRESS
Solomon Hall	1715 Pennsylvania

Cause of death must be plainly written, and should not be prepared by undertaker. Each statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Vesalle

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47386 — 79 D47386

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 118 or 21 n. Fremont St.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Vesall

(Residence in Baltimore: No. 118 or 21 n. St.; 35 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Col	~~Widow~~

6-DATE OF BIRTH, June 18th (Month) (Day), 1867 (Year)

7-AGE.	If LESS than 1 day,
53 yrs. 3 mos. 29 da.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Serena Young

(Address) 118 N. 21st

15- ROBERT B. LITTLE

Filed OCT 19 1920, 191.. Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1920, to Oct 16 1920, that I saw her alive on Oct 15 1920, and that death occurred, on the date stated above, at 8 9 m.

The CAUSE OF DEATH* was as follows:

Acute Dilitation of the heart / (Chronic)

..... (Duration) .....yrs. .....mos. .....da.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....da.

(Signed) Wm H Pearce M. D.

Oct 18, 1920 (Address) 2405 E. Clas St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cem'y	Oct 19, 1920
20-UNDERTAKER George H. Holland	ADDRESS 1631 Harford Hillsdale

Spec.—6-8-19—H. P. Co.—1000 Bks.

D47387 HEALTH DEPARTMENT—CITY OF BALTIMORE. D47387

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Echodale & Belmont Aves ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Robert Brown

(a) RESIDENCE. NO. Echodale & Belmont Aves ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26, 1920

7 AGE: Years — Months 2 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Bartlett Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Madge L. Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Joseph B. Brown

(Address) Echodale & Belmont Ave.

15 Filed OCT 19 1920 ROBERT P. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 11th, 1920, to Oct 18th 20, that I last saw h[illegible] alive on Oct 18, 1920, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Decomposition

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Cardio-Respiratory Paralysis

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) J W Clift M. D.

Oct 18 1920 (Address) 1312 N. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Oct 19 1920
20 UNDERTAKER E. A. Middlefield	ADDRESS 501 E 20th St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

647388

HEALTH DEPARTMENT—CITY OF BALTIMORE

647388

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benedict—Turnelly.

(a) RESIDENCE. NO. Treadon & Valley Sts. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? Yes yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower of

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Murphy, Annie Downing.

6 DATE OF BIRTH (month, day, and year) May 2-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	5.	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Hugh D Turnelly.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Annie Downing

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Sister Florence. (Address) Treadon & Valley Sts.

15 Filed OCT 18 1920 ROBERT E KRAMER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 1919 to , 19 ,

that I last saw h in alive on Oct 17 , 1920 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Downer, M. D.

Oct 19, 1920 (Address) 1135 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Washington D.C. Oct 20 1920

20 UNDERTAKER — ADDRESS

H. C. Wiedefeld 914 Greenmt

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Mules. 1047389

1047389

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Edmondson Ave (St.) Old Frederick Rd (Ward) 18

2-FULL NAME Thos. J. Mules

(a) RESIDENCE. No. Edmondson Ave & Frederick Rd St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma C.

6 DATE OF BIRTH (month, day, and year) Feb 16/1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Thomas H. Mules

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Edith Bowden (Address) Edmondson Ave & Old York Road

15 Filed OCT 19 1920 19 ROBERT E. LEAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17/20 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 1920 to Oct 17 1920, that I last saw h[e] alive on Oct 17 1920, and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Dilated Heart

(duration) yrs. 10 mos. — ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) 6 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Signs

(Signed) A. Reuben Oh M. D.

19 (Address) 1340 Eden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemty	Oct 20/1920
20 UNDERTAKER	ADDRESS
W. W. Shivin	1018 Edmondson Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 47390

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 47390

64

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 S. Linwood ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Tiedler

(a) RESIDENCE. NO. 608 S. Linwood ave ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Tiedler

6 DATE OF BIRTH (month, day, and year) Oct 4th 1862

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Wachee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Joseph Tiedler Son

(Address) 608 S. Linwood ave.

15 Filed OCT 19 1920 . 19 Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17th 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 12 . 1920 . to Oct 17 . 1920 .

that I last saw h alive on 16th . 1920 .

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph J Nurkin M. D

. 19 (Address) 1634 E Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Oct. 20th 1920
20 UNDERTAKER Lilly + Zeiler	ADDRESS 404 S. Wolfe St

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47391 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47391

X 120

CERTIFICATE OF DEATH

1-PLACE OF DEATH Southern Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2510 Greenmount St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Pauline Hope.

(Residence in Baltimore: No. Southern Hospital St.; ....yrs.... mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~ (Write the word.)
Female	White	M W

6-DATE OF BIRTH, Sept 12, 1892 (Month) (Day) (Year)

7-AGE	If LESS than 1 day,
28 yrs. 1 mos. 0 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Knoxville

PARENTS.

10-NAME OF FATHER, Wm McClannahan

11-BIRTHPLACE OF FATHER (State or Country), Knoxville, Tenn

12-MAIDEN NAME OF MOTHER Jennie Thompson

13-BIRTHPLACE OF MOTHER (State or Country), Tenn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Myrtle E. Thrasher

(Address) 406 W. Pine Ave

15- OCT 19 1920 Robert P. Harrison,
Filed....., 191.....
Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 19, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 29 1920, to Oct 19 1920, that I saw her alive on Oct 18 1920, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

1) Pregnancy (Term Duration)
2) Chronic Interstitial Nephritis
3) Bronchopneumonia (Duration) (3) yrs. (1) mos. ds.

CONTRIBUTORY (Secondary) acute dilatation Heart (Duration) yrs. mos. ds.

(Signed) W. Arthur Dudley M. D.

Oct 19, 1920. (Address) 1611 Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 20 ds. In the State ....yrs. ....mos. 22 ds.

Where was disease contracted, if not at place of death? Knoxville, Tenn

Former or usual residence Knoxville, Tenn

19-PLACE OF BURIAL OR REMOVAL, Knoxville Tenn — DATE OF BURIAL, Oct 17, 1920

20-UNDERTAKER Walter Davis — ADDRESS 330 Paine St

Important. See instructions on back of certificate.

D.47392 HEALTH DEPARTMENT--CITY OF BALTIMORE D.47392

CERTIFICATE OF DEATH

97

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 1804 N. Broadway ST.: 8 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Harry E. Weidman

(Residence in Baltimore: No. 1804 N. Broadway ST.: 1 yrs. 4 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: June 15th, 1919 (Month) (Day) (Year)

7 AGE: 1 yrs. 4 mos. 3 ds. If LESS than 1 day ..... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None (Child)
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Harry E. Weidman

11 BIRTHPLACE OF FATHER (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Bessie Utermohle

13 BIRTHPLACE OF MOTHER (State or country): Balto Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry E. Weidman

(Address) 804 N. Broadway

15 Robert P. Harrison,

Filed ..... 191 .....

CT 9 1920 Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October 18, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1920, to, Oct 18 1920, that I saw him alive on Oct 17, 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cardiac failure following
a acute (lobar) Pneumonia

(Duration) ..... yrs. ..... mos. 20 ds

Contributory (SECONDARY) Chronic Malnutrition –
Chronic Intestinal Indigestion

(Duration) ..... yrs. 4 mos. ..... ds.

(Signed) Carroll Lockard M. D.

Oct 19, 1920 (Address) 43 Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Oct. 20, 1920

20 UNDERTAKER: George A. Putty

ADDRESS: 1735 Hanford ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact ... of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

1047393 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047393.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp. St.; 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian M. Biddle Hackett

(Residence in Baltimore: No. 645 N. Paca St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, (Month) (Day) 1885 (Year)

7-AGE, 35 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): Housework

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Anne Hackett

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Hackett

(Address) 645 Paca St

15- OCT 20 1920 Filed, 191.. ROBERT B KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) 10 (Day) 18, (Year) 1920

17- I HEREBY CERTIFY, That I attended deceased from Oct. 14 1920, to Oct. 18 1920, that I saw h[illegible] alive on Oct. 17 1920, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Toxemia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Typhoid Fever

(Duration) yrs. about mos. 1 ds.

(Signed) J. H. Tompkins M. D.

10/18/, 1920 (Address) 1019 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Md — DATE OF BURIAL, Oct. 20, 1920

20-UNDERTAKER John H. Toadvine — ADDRESS 143 Whitehall St.

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

647394 HEALTH DEPARTMENT—CITY OF BALTIMORE 647394

CERTIFICATE OF DEATH. 126

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. City Hospital, Bay ST. 126 WARD)

2-FULL NAME Robert Jordan. 224 Myrtle Ave.

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. 25 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60(?)			

8 OCCUPATION OF DECEASED 887

(a) Trade, profession or particular kind of work Unknown.

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer For the Governor of Louisiana

9 BIRTHPLACE (city or town) (State or country) Supposed to be born in Ball 25 Georgia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Unknown

14 Informant Records (Address) New City Hospital

15 Filed ..... 19.... ROBERT E. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1920, to Oct. 16, 1920 that I last saw h... alive on Oct. 16, 1920, and that death occurred, on the date stated above, at 12 N.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis
(no cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Benign prostatic hypertrophy (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) V. B. Sherman, M. D.

Oct 17. 1920 (Address) City Hospital, Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Oct 19. 1920
20 UNDERTAKER Mrs R J Elliott	ADDRESS 1725 Ashland Av

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

0647395 HEALTH DEPARTMENT—CITY OF BALTIMORE 0647395

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2708 Elliot St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Mary Lubinski

(Residence in Baltimore: No. 2708 Elliot St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb. 23, 1920 (Month) (Day) (Year)

7-AGE, ... yrs. 8 mos. 26 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Walter Lubinsky

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Theresa Medinsky

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Lubinsky

(Address) 2708 Elliot St

15- OCT 20 1920 Filed ..... 191.... ROBERT B KRAUTER Registrar. Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 19, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 7 1920, to Oct 18 1920, that I saw h[illegible] alive on Oct 18 1920, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

Contributory Pneumonia

(Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Oct 21, 1920 (Address) 3330 Johns...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus Bem — DATE OF BURIAL, Oct 22, 1920

20-UNDERTAKER Stephen Stalkowski — ADDRESS 1005 Lemmon Ave

Important. See instructions on back of Certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D47396 HEALTH DEPARTMENT—CITY OF BALTIMORE D47396

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Home ST.; 10 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr. Joseph Siegel

(Residence in Baltimore: No. 1170 Madison ave. St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
M	W	Widower

6-DATE OF BIRTH, ..., 1855
(Month) (Day) (Year)

7-AGE, 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Optician 786
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Levis

(Address) 1411 E. Baltimore St.

15- Filed OCT 20 1920, 191.... ROBERT B. KRAUTER Registrar.

Burial Permit 01671

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 18, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-14 1920, to 10-18 1920, that I saw him alive on 10-18 1920, and that death occurred, on the date stated above, at 6:40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver, and Metastasis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) B. Sachs M.D. M. D.

10-19, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 18 mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 1170 Madison ave

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Friendship	10/20, 1920
20-UNDERTAKER Jack Levis	ADDRESS 1411 E Balto

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

047397

HEALTH DEPARTMENT—CITY OF BALTIMORE

047397

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 246 N. Exeter St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Kushner

(Residence in Baltimore: No. 246 N. Exeter St. St.; 71 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1863 (Year)

7-AGE, 57 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ooo

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis

(Address) 1411 E Balto St

15- OCT 20 1920 ROBERT E KRAUTER

Filed....., 191.... Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 19 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 13 1920, to Oct 17 1920, that I saw her alive on Oct 17 1920, and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

(Duration) yrs. mos. 5 ds.

(Signed) A. L. Hornstein M. D.

Oct 20, 1920 (Address) 733 Cleveland St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Lebanon Cemetery — DATE OF BURIAL, Oct 20, 1920

20-UNDERTAKER Jos K Louis — ADDRESS 1411 E Balto.

Important. See instructions on back of Certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D47398 HEALTH DEPARTMENT—CITY OF BALTIMORE D47398

100

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Kemper (Komber)

(Residence in Baltimore: No. 416 S. Clinton St.; 21 yrs., 1 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept. (Month) 6th (Day), 1899 (Year)

7-AGE, 21 yrs. 1 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER Frederick Kemper

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Helen C. Bernard

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick Kemper

(Address) 416 S. Clinton St.

15-

Filed OCT 20 1920, 191.....

ROBERT A KRAUTER

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 3 1920, to October 17 1920, that I saw her alive on October 17 1920, and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Ludwig's Angina

Septicemia (Streptococcus)

(Duration) 0 yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) 0 yrs. 0 mos. 2 ds.

(Signed) Louis Sachs M. D.

October 17 1920. (Address) The Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 14 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem.

DATE OF BURIAL, Oct. 20th, 1920

20-UNDERTAKER Philip Herrig

ADDRESS 2016 Orleans St.

Important. See instructions for back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47399

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D47399

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 526 N. Belnord Ave ST.: 7 WARD)

2-FULL NAME. Mary Primus

(a) RESIDENCE. No. 526 N. Belnord Av- ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ ~~WIFE of~~ Anton Primus

6 DATE OF BIRTH (month, day, and year) May 31st 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Anton Primus

(Address): 526 N. Belnord Ave-

15 Filed OCT 20 1920 ROBERT R KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 4 1919, to Oct 18 1920, that I last saw h.. alive on 11 11 1920, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Phthisis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? microscope

(Signed) A. G. Beaux M. D.

10/19 1920 (Address) 2020 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cemetery	Oct 21st 1920

20 UNDERTAKER: Philip Herwig ADDRESS 2016 Orleans St.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47400

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47400

CERTIFICATE OF DEATH.

1920

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2314 Harford Ave St.. 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Sachs

(a) RESIDENCE. NO. 2314 Harford Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 6 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Margaret Sachs

6 DATE OF BIRTH (month, day, and year) Mar 22-57

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dairyman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Himself

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Albert Sachs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henriette Figgie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Sachs

(Address) 2314 Harford ave

15 Filed OCT 20 1920 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 16 1920 to Oct 17th 1920

that I last saw him alive on Oct 16th 1920

and that death occurred, on the date stated above, at 1 30 A m.

The CAUSE OF DEATH* was as follows: Chronic

Interstitial Nephritis

Contributory Varicocele

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D W Sclover, M. D.

1920 (Address) 1501 E Eager.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem.

DATE OF BURIAL Oct 20 1920

20 UNDERTAKER Philip Hennig

ADDRESS 2016 Orleans

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47401

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 D 47401

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 N. Milton Ave ST.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth N. Valentine

(a) RESIDENCE. No. 817 N. Milton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18/20

7 AGE — Years: — Months: 4 Days: 1 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto' Md.

PARENTS

10 NAME OF FATHER: Henry A Valentine

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto' Md.

12 MAIDEN NAME OF MOTHER: Irene L. Stratz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto' Md.

14 Informant: Henry A. Valentine
(Address) 817 N. Milton Ave

15 Filed OCT 20 1920 19 Registrar

ROUTE Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19th 1920

17

I HEREBY CERTIFY, That I attended deceased from June 18, 1920, to Oct 19, 1920,

that I last saw h.e alive on Oct 19, 1920,

and that death occurred, on the date stated above, at 8:30 p m.

The CAUSE OF DEATH* was as follows:

Insanity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Birth.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Alma B Leonard, M. D.

19 Address 718 N. Patterson Pk ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Oct. 20th 1920
20 UNDERTAKER	ADDRESS
Philip Herwig	Orleans St.

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047402 HEALTH DEPARTMENT—CITY OF BALTIMORE 047402

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Steinberg

(a) RESIDENCE. No. 2302 Lafayette Ave. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Can Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Frederick Steinberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed OCT 20 1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 19 19 20

17 I HEREBY CERTIFY, That I attended deceased from October 12, 19 20 to October 19, 19 20 that I last saw him alive on October 19, 19 20 and that death occurred, on the date stated above, at 10:25 A. m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical test

(Signed) W. H. Forman, M. D.

10/19/19 20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Oct 21- 1920
20 UNDERTAKER William Cook	ADDRESS 502 E. North Ave.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47403

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47403

CERTIFICATE OF DEATH.

REGISTERED NO.:

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 944 Burgundy ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Zemalis.

(a) RESIDENCE. No. 944 Burgundy St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Apr. 15-17

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	6.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Joseph Zemalis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania Russia

12 MAIDEN NAME OF MOTHER Petronia Stalas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant (Address) Jos Zemalis 944 Burgundy

15 Filed . 19 ROBERT B. KRAUTER Registrar

OCT 20 1920 Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1920, to Oct 20, 1920, that I last saw him alive on Oct 20, 1920, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Empyema. Pneumonia.

Contributory Influenza

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) M C Fillinger M. D.

10/22/20 (Address) 682 Cal Ave —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	10/20 1920
20 UNDERTAKER	ADDRESS
John Grebliunas	425 S. Paca

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 47404

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

176 D 47404

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Fort McHenry, Balto. Md. ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gilbert Flynt,

(Residence in Baltimore: No. 2017 Brunt St., Baltimore, Md. St.; ...yrs.. ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE, 61 yrs. XX mos. XX ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Seaman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar T. Rosenbush Registrar

(Address) Fort McHenry, Balto Md.

15-

Filed OCT 20 1920 191... ROBERT B KRAUTER Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... October 18th, 1920, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1920, to October 18, 1920, that I saw him alive on October 18, 1920, and that death occurred, on the date stated above, at 12:25 P m.

The CAUSE OF DEATH* was as follows:

Tumors of prostate (benign)

.....

.....

..... (Duration) unknown yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas R. Payne M. D.

Oct. 18, 1920 (Address) Fort McHenry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 19 ds. In the State Md yrs. ..... mos. 19 ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Unknown

19-PLACE OF BURIAL OR REMOVAL, Northumberland Co Va Timberneck — DATE OF BURIAL, Oct 20, 1920

20-UNDERTAKER John H Owens — ADDRESS 538 Dolphin St

D47405

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X175 D47405

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. Mercy Hospital St.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Baker

(Residence in Baltimore: No. Woodlawn, Md. St.; yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	White	Married

6-DATE OF BIRTH, January 13th. 1867., 1
(Month) (Day) (Year)

7-AGE, 53 yrs. 9 mos. 4 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None. 37
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Francis Nicholson.

11-BIRTHPLACE OF FATHER (State or Country), France.

12-MAIDEN NAME OF MOTHER Christina Ford.

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Baker.(husband)

(Address) Woodlawn Md.

15- ROBERT B KRAUTER

Filed....., 191.....
Burial Permit (Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 17th. 1920, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of 5th&6th Cervical Vertebrae thrown from a wagon in collision with car #331 U.Ry & E Co Accident (Duration) yrs. 1 mos. 26 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (Duration) yrs. mos. 10 ds.

(Signed) Otto K. Reinhardt (Coroner)

Oct 18, 1920. (Address) 1017 St Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs. 1 mos. 26 ds.

Where was disease contracted, if not at place of death? Owings Oak road near Woodlawn.

Former or usual residence Woodlawn Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn Cem.	Oct 20, 19 20
20-UNDERTAKER Joseph B. Cook	ADDRESS 1003 W Balto St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47406

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 So. Gilmor St. ST.: 19 WARD)

2-FULL NAME Thelma M. Warner

(a) RESIDENCE. No. 120 So. Gilmor St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED No. 168 D47406

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1902

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
18	8	5	

8 OCCUPATION OF DECEASED 009

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Gas & Electric Co

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Warner

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Peterson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant John Warner
(Address) 120 So. Gilmor St.

15 Filed , 19 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1920, to Oct. 17, 1920, that I last saw h[illegible] alive on Oct 17, 1920, and that death occurred, on the date stated above, at 7.50 a.m.

The CAUSE OF DEATH* was as follows:

Subacute Endocarditis - Mitral Stenosis & regurgitation - Subacute Rheumatic Fever, Chronic Nephritis

Paranasal Sinusitis (duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Mesenteric Embolism (duration) yrs. mos. 1/4 ds.

18 Where was disease contracted If not at place of death? At place of death.

Did an operation precede death? Yes Date of May 6 1920

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) W B Levin, M. D.

, 19 (Address) The Walbert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Oct 20 1920
20 UNDERTAKER C. & L. B. Cook	ADDRESS 1003 N. Balto St

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D47407

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47407

CERTIFICATE OF DEATH.

REGISTERED NO. C 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 N. Duncan ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James N. Porter

(Residence in Baltimore: No. 501 N. Duncan St.; Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) M

6-DATE OF BIRTH, Sept 8, 18[illegible]

7-AGE, 38 yrs. 1 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clothier
(b) General nature of industry, business, or establishment in which employed (or employer): 157

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, James Port Porter

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Crump

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche Porter

(Address) 501 N. Duncan St

15-

Filed OCT 9 1918, 191...

ROBERT B KRAUTER
BUREAU POINT CLERK
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 8, 1918
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 4 1918, to Oct 8 1918, that I saw him alive on Oct 8 1918, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Complications

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Heart disease

(Duration) ....yrs. 1 mos. ....ds.

(Signed) [illegible] M. D.

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn, Cem'ty	Oct 9/1918
20-UNDERTAKER	**ADDRESS**
Milton Davis	413 N Eden St

D47408

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D47408

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 8th St.) Morrell Pk (WARD) 25

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jannie B Hooper

(Residence in Baltimore: No. 8th St.) Morrell Pk

(If non-resident give usual place of abode.) (How long in City, if less than life? 30 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
female	White	Widow

6 DATE OF BIRTH: Dec 2, 1860 (Month) (Day) (Year)

7 AGE: 59 yrs. 10 mos. 18 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Stone cutter
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Mass. Dec.

PARENTS

10 NAME OF FATHER: John Reese

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Virginia Bowman

13 BIRTHPLACE OF MOTHER (State or country): Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr J Boyce

(Address) Morrell Park Md

15 ROBERT B KRAUTER

Filed ..... 191 Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 19, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jany 26, 1920 to Oct 19 1920

that I saw her alive on Oct 18 1920

and that death occurred, on the date stated above, at 4.50 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 7 mos. ds

Contributory (SECONDARY) same

(Duration) yrs. 7 mos. ds.

(Signed) Geo. McKinley M. D.

Oct 19, 1920 (Address) Morrell Park Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Oct 22, 1920

20 UNDERTAKER: Geo Lumbrick Sons — ADDRESS: 847 N Paca St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D47409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D47409

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 818 S Bond ST.; 3rd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Sobolewski

(a) RESIDENCE No. 818 S Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Anthony Sobolewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Bronislawa Bialik

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Anthony Sobolewski
(Address) 818 S Bond

15 OCT 20 1920. ROBERT E. LEE ELDER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19- 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 17- 1920, to Oct 19- 1920, that I last saw h[er] alive on Oct 19 1920, and that death occurred, on the date stated above, at 7.50 P. m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis -

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Genuine Cholera

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? City -

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) [illegible] M. D.

, 19 (Address) 1258 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	October 21 1920

20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

THIS IS very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47410

D 47410

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Annapolis ave ST.; 25 WARD)

2-FULL NAME. Ida Edler

(a) RESIDENCE. NO. Annapolis ave ST., 25 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Edler

6 DATE OF BIRTH (month, day, and year): Oct 12-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co. Md

PARENTS

10 NAME OF FATHER: Jacob Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Md

12 MAIDEN NAME OF MOTHER: Sarah Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md

14 Informant (Address): John Edler Annapolis ave Ext Wmore

15 Filed ..... 19 ..... ROBERT B. [illegible] Registrar

OCT 20 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 18 1920

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to Oct 18, 1920

that I last saw h. alive on Oct 17, 1920

and that death occurred, on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): same

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo L McKeffen, M. D.

Oct 19 1920 (Address) Monroe Park Med

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 20 1920
20 UNDERTAKER	ADDRESS
George L Lehmat & Bro	2101 Fredk Ave

FOR IS very Important. See Instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D47411 HEALTH DEPARTMENT—CITY OF BALTIMORE D47411

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 N. Bond St. 8 WARD)

REGISTERED No. C

(If death occurred in a hospital or Institution, give Its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Veronica Traynor

(Residence in Baltimore: No. 1108 N. Bond St.: 20 yrs., 9 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Jan 28 1900 (Month) (Day) (Year)

7-AGE, 20 yrs. 9 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Worked on Underwear
(b) General nature of industry, business, or establishment in which employed (or employer): 196

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER, John Traynor

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Margaret Beatty.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Traynor

(Address) 1108 N. Bond St

15- Filed OCT 20 1920 191 ROBERT B KRAUTER Registrar

BURIAL PERMIT ISSUED

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 17, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 14 1920 to Oct 17 1920 that I saw h[er] alive on Oct 17 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

a. Typhoid Fever

(Duration) 1 yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. Thomas M. D.

Oct 19, 1920 (Address) 122 D. Caroll Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, Oct 21 1920

20-UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047412 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 1047412

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2004 E. Biddle ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. B. Cole

(a) RESIDENCE. NO. 2004 E. Biddle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie A. Cole

6 DATE OF BIRTH (month, day, and year) May 21-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59.	5	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) City Water Dept

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John H. Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret Peterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Given

14 Informant Lillie A. Cole (Address) 2004 E. Biddle St

15 Filed OCT 20 1920 By ROBERT B. KRAUTHOFF Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18th 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to Oct 18, 1920, that I last saw him alive on Oct 18, 1920, and that death occurred, on the date stated above, at 1130 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis (duration) 1 yrs. mos. days

CONTRIBUTORY (Secondary) Chronic Valvular Heart (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) H. C. Hamer M. D.

Oct 19 20 (Address) 1301 N Port Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL OCT 21 1920

20 UNDERTAKER Geo. M. Fink & Son,

ADDRESS 811 N Wolfe

Funeral Directors & Embalmers.

FOR is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

1947413 HEALTH DEPARTMENT—CITY OF BALTIMORE 1947413

92-119

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 Hanford ave ST.; 9 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hannah Ahler

(Residence in Baltimore: No. 1628 Hanford ave St. Life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Nov 30 (Month) (Day), 1849 (Year)

7-AGE, 70 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Work

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER August Leute

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Sophia Brandt

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L Ahler

(Address) 1628 Hanford Ave

15- OCT 20 1920 ROBERT E KRAUTER

Filed ....., 191.... Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 18 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1920, to Oct 18 1920, that I saw ~~her~~ alive on Oct 18 1920, and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Nephritis, Acute (Duration) ..... yrs. ..... mos. 8 ds.

(Signed) Wm J. Kratzer M. D.

Oct 19, 1920 (Address) 2128 St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Dale Cemetery DATE OF BURIAL, Oct 21, 1920

20-UNDERTAKER Chas J Schmick & Co ADDRESS 1442 Bway

Spec.—6-9-19—H. P. Co.—1000 Blks.

D47414. HEALTH DEPARTMENT—CITY OF BALTIMORE D47414

CERTIFICATE OF DEATH. 10-091

1-PLACE OF DEATH 1607 Hayes St. REGISTERED NO.....

CITY OF BALTIMORE: (No. 1607 Hayes ST.: 8 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew J. Campbell

(a) RESIDENCE. NO. 1607 Hayes ST., 8 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknow

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Asst. bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer) 015
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS
10 NAME OF FATHER Andrew J Campbell
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md
12 MAIDEN NAME OF MOTHER Sarah J Coon
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wilmington Del

14 Informant Sarah J Campbell
(Address) 1607 Hayes St

15 Filed OCT 20 1920, 19... Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1920, to Oct 19, 1920, that I last saw him alive on Oct 19, 1920, and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
(duration) yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza
(duration) ... yrs. ... mos. 6 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) A W Macdonald M. D.
Oct 19 1920 (Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery Lee — DATE OF BURIAL Oct 22 1920

20 UNDERTAKER Robt F Tempen — ADDRESS 1424 Bway

THIS is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47415

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47415

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital St., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bell

(a) RESIDENCE. NO. 528 N Amity St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Oct 25 - 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	33	~~11~~ Oct	~~20~~ 25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John Bell

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Eddie Hood

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Eddie Hood
(Address) 1218 Center ave

15 Filed OCT 20 1920 ROBERT P. ERASER Registrar
Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/18/ 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1920, to Oct 18, 1920, that I last saw h. alive on Oct 18, 1920, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Intraventricular Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic + Clinical

(Signed) Frank C. Marino M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury cemetery	Oct 20 1920
20 UNDERTAKER	ADDRESS
P B Groll	1705 McElderry

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D47416

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47416

CERTIFICATE OF DEATH.

74

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No St. Agnes Hosp. St.: 12 WARD)

2-FULL NAME Alvin A. Winship.

(a) RESIDENCE. NO 229 E. 33rd St. Balt. ST., 25 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Winship

6 DATE OF BIRTH (month, day, and year) Aug 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48 yrs.			

8 OCCUPATION OF DECEASED 031

(a) Trade, profession or particular kind of work Supt. of Machining.

(b) General nature of industry, business, or establishment in which employed (or employer) Navy Yard

(c) Name of employer Ship Building Co Brooklyn N.Y.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Alvin A. Winship.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Arline Engle.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Montgomery

14 Informant Rose Winship (Address) 229 E 33rd St.

15 Filed OCT 20 1920 19 ROBERT E SLAUGHTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17 1920

17 I HEREBY CERTIFY, That I attended deceased from 10-6, 1920, to 10-17, 1920, that I last saw him alive on 10-17, 1920, and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) 1 yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-11-20

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) A. Magruder, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	10/20d 1920

20 UNDERTAKER J. J. Moran ADDRESS 3000 E Balto St

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

047417 HEALTH DEPARTMENT—CITY OF BALTIMORE 047417

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1925 W. Lombard ST.; 70 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Dmhoff.

(Residence in Baltimore: No. 1925 W. Lombard St.; 54 yrs., — mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married.

6-DATE OF BIRTH, October (Month) 19 (Day), 1866 (Year)

7-AGE, 54 yrs. no mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: brush maker. No
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Lena Dmhoff (wife)

(Address) 1925 W. Lombard St

15-

Filed OCT 20 1920, 191.... ROBERT B KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 19 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 24 1920, to October 19 1920, that I saw him alive on October 11 1920, and that death occurred, on the date stated above, at 3. P. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart.

(Duration) a few minutes. yrs. mos. ds.

CONTRIBUTORY (Secondary) Organic heart disease

(Duration) unknown yrs. mos. ds.

(Signed) Chester Roland, M. D.

10-19-, 1920. (Address) 2532 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Oct 21, 191..
20-UNDERTAKER George Jewell	ADDRESS 600 Eutaw Pl

Spec.—8-24-14—M. & T.—2000 Bks.

D47418 HEALTH DEPARTMENT—CITY OF BALTIMORE D47418

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2704 Guilford Ave St.; 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Littleton H. Boggs.

(Residence in Baltimore: No. 2704 Guilford Ave St.; 38 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July (Month) 21 (Day), 1881 (Year)

7-AGE, 39 yrs. 2 mos. 27 ds. If LESS than 1 day, ...hrs. or ....min.? 109

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk Bldrk.
(b) General nature of industry, business, or establishment in which employed (or employer): Record Dept.

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Thomas W. Boggs

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Susan A. Chandler

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Chandler Newman

(Address) 1139 E. Eager St.

15- OCT 20 1920 ROBERT E KRAUTER

Filed....., 191.... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 18th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 10 1920, to Oct 18 1920, that I saw h im alive on October 18 1920, and that death occurred, on the date stated above, at 9.20 p.m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(Duration) ....yrs. ....mos. 5 ds.

(Signed) Geo. M. Gill M.D.

Oct 19, 1920 (Address) 2431 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Oct 21, 1920
20-UNDERTAKER	ADDRESS
Geo. J. Smith	605 W. Lafayette St

Spec.—8-24-14—M. & T.—2000 Bks.

D.47419 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47419

CERTIFICATE OF DEATH.

9

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1308 Wilcox ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen M. Zellers

(Residence in Baltimore: No. 1308 Wilcox St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F	W	Single

6-DATE OF BIRTH, Nov (Month) 29 (Day), 1917 (Year)

7-AGE,	If LESS than 1 day,
2 yrs. 9 mos. 20 ds.	....hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Harry F Zellers

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Theresa Mooney

13-BIRTHPLACE OF MOTHER (State or Country). ~~Balto~~ New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Zellers

(Address) 1308 Wilcox St

15-

Filed Oct 20, 1920, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 19 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from 10-18 1920, to 10-19 1920, that I saw h[er] alive on 10-19 1920, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Edema of Lungs

Bronchitis (Duration) ....yrs. ....mos. 7 ds.

(Signed) Dr Benesch M. D.

10 20, 1920 (Address) 917 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Oct 21, 1920

20-UNDERTAKER Robt J Turner — ADDRESS 1842 N Bway

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.47420 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47420

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Clarinda 1602 N. Gilmor ST.: 15 WARD) REGISTERED NO. 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Clarinda~~ Cin Nettleships

(a) RESIDENCE. NO. 1602 N. Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 7, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Alvin E Nettleships

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Nettleships

12 MAIDEN NAME OF MOTHER Charlotte Boyd

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Alvin E. Nettleship
(Address) 1602 N. Gilmor St.

15 Filed OCT 20 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 18 1920, to Oct 20 1920, that I last saw her alive on Oct 20 1920, and that death occurred, on the date stated above, at 8 45 a m.

The CAUSE OF DEATH* was as follows:

Membranous Croup

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A C Simmons, M. D.

19 (Address) 1203 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem — DATE OF BURIAL Oct 21 1920

20 UNDERTAKER Mr & Mrs John N. Teufel — ADDRESS 801 N. Fayette

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 47421 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 47421

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Christ Institution Hospital St.; 14 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Taylor

(Residence in Baltimore: No. 512 Baker St.; ..... yrs., ... mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR ~~OR RACE~~. Colored

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED;~~ (*Write* the word.) Married

6-DATE OF BIRTH, [illegible] (Month) 1 (Day) 1860 (Year)

7-AGE. 60 yrs. 4 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Buckannon W. Va.

PARENTS.

10-NAME OF FATHER, Samuel Lesley

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Cora Taylor

(Address) Buckannon W. Va.

15- Filed OCT 20 1920, 191.....

Robert P. Harrison, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 20, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 12 1920, to Oct. 20 1920, that I saw her alive on Oct 20 1920, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Nervous Strain

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) W. H. Montague M. D.

Oct. 20, 1920 (Address) 233 N. Paulton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Buckannon W. Va.

19-PLACE OF BURIAL OR REMOVAL, Buckannon W. Va. DATE OF BURIAL, Oct. 20, 1920

20-UNDERTAKER George A. Holland ADDRESS 1631 Vernon

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47422 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 47422

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1213 Light St. REGISTERED NO. 15-78

CITY OF BALTIMORE: (No. ~~Dougl Balto Hos~~ ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernon A Bivens Jr

(a) RESIDENCE. NO. 2039 N Fulton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 20 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work c 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Vernon A Bivens Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn'd

12 MAIDEN NAME OF MOTHER Sadie Grey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Sadie Bivens
(Address) 2039 N Fulton Ave

15 Filed 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-20 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1920, to Oct. 20, 1920, that I last saw him alive on Oct. 20, 1920, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Septremia
(Streptococcus)
oom

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. C. Conte Jr. M. D.

. 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Oct 22 1920
20 UNDERTAKER Wm J Tuckner & Son	ADDRESS Balto Md

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

047423. HEALTH DEPARTMENT—CITY OF BALTIMORE 047423

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child's Hospital St.; 18 WARD) 15

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Stoops.

(Residence in Baltimore: No. Nursery & Child's Hospital St.; yrs., 3 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Sigle

6-DATE OF BIRTH, Nov. (Month) 3 (Day), 1919 (Year)

7-AGE, ...yrs. 11 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Sam Stoops

11-BIRTHPLACE OF FATHER (State or Country). unknown

12-MAIDEN NAME OF MOTHER Ada Smith

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ada L. Smith,

(Address) 1020 N. Gay St.

15- OCT 21 1920 Filed....., 191.... ROBERT B KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 20 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1, 1920, to Oct 20 1920, that I saw h in alive on Oct 20, 1920, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Severe Malnutrition

(Duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) L. J. Finegan M. D.

10/20, 1920 (Address) 2002 E Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State N/R yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 1020 N. Gay St. Balto. Md.

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL.
Loudon Park	Oct. 21, 1920
20-UNDERTAKER George J. Smith	ADDRESS 1000 N. Gay St.

D47424 HEALTH DEPARTMENT—CITY OF BALTIMORE D47424

172

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital 3 WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Puzzychai

(Residence in Baltimore: No. 1614 Eastern ave

Sex 20 yrs., 0 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Mal

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sigle

6-DATE OF BIRTH, Unknown (Month) (Day), 1885 (Year)

7-AGE, about 35 yrs. 0 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Copper Works

9-BIRTHPLACE, (State or Country), Poland,

PARENTS.

10-NAME OF FATHER, Walenty Puzzyck

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Tekla Jankowska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Severyn Kisielewski

(Address) 1614 Eastern Ave

15- OCT 21 1920 ROBERT E KRAUTER

Filed....., 191.... Registrar. Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 19, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic fall down Stairs, (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) M. D. (Coroner.)

10-22 1920 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Oct 21 1920

UNDERTAKER William Diamond — ADDRESS 1618 Eastern Ave.

important. See instructions on back of certificate.

D47425 HEALTH DEPARTMENT—CITY OF BALTIMORE D47425

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. Md. Gen. Hosp., St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Enos Ford

(Residence in Baltimore: No. 1503 Linden Ave St.; yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	married

6-DATE OF BIRTH, January (Month) 19 (Day), 1876 (Year)

7-AGE, 44 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): (General) 040

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Ford

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Bell

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith E. Ford

(Address) 5320 Melvin Ave

15- Filed OCT 21 1920, 191. ROBERT E. KRAUTER Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 19 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
Automobile Accident (Immediate)
(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. H. Hennessy M. D. (Coroner.)

Oct. 21, 1920 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death Md. Gen. Hosp. yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Cockeysville, Md.

Former or usual residence 1503 Linden Ave.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Wyman Md.	10/24/20 19
20-UNDERTAKER	ADDRESS
Wm Cook	502 E. North Ave

IMPORTANT. See instructions on back of certificate.

D47426 Laughlin D47426

HEALTH DEPARTMENT—CITY OF BALTIMORE

Lombard & 7th

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Lombard & 7th St.; 6 Ward) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Laughlin

(Residence in Baltimore: No. 300 E. Baltimore St. St.(yrs., 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 60 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): 106

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr Benson

(Address) Harrow Point Md

15- Filed OCT 21 1920, 191.... ROBERT B KRAUTER Registrar. Burial Permit Issued

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH ..... October 21 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas Paul Austin M. D.
(Coroner.)

Oct 21 1920 (Address) 1715 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Altoona Pa	Oct 21, 1920
20-UNDERTAKER	ADDRESS
John F Denny	715 Eight st

1047427 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047427

CERTIFICATE OF DEATH.

175-002

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hugo Steiner

(Residence in Baltimore: No. 3035 Presbman St. 45 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, Nov 14, 1865
(Month) (Day) (Year)

7-AGE, 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Samul Steiner

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Anna Kryser

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Jaffe

(Address) 3035 Presbman St

15- OCT 21 1920 ROBERT I. KRAUTER

Filed ....., 191.... Registrar.

Burial Permit Issued

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 19, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry)~~ find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(Duration) yrs. mos. 2m ds.

CONTRIBUTORY (Secondary) from from Motor Cycle

(Duration) yrs. mos. 2 ds.

(Signed) J. K. Gorsuch M. D.
(Coroner.)

10-24-1920 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn	Oct 21, 1920
20-UNDERTAKER	ADDRESS
J. Aikens & Co	[illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47428 — 91 D47428

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital — REGISTERED NO. C

CITY OF BALTIMORE: (No. ..... ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eli Arkin

(Residence in Baltimore: No. 1506 E Pratt St St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	widower

6-DATE OF BIRTH, Unknown (Month) (Day), 1875 (Year)

7-AGE, 45 yrs. mos. ds. — If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country), Russia.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unkon

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis

(Address) 1411 E Balto St

15- OCT 21 1920, 191 ROBERT E KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 20 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10/15 1920, to 10/20 1920, that I saw him alive on 10/20 1920, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Bronchus Pneumonia

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Myocardial Insuff.

(Duration) yrs. mos. ds.

(Signed) Chas R. Goldborough M. D.

10/21, 1920 (Address) University Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 5 ds. In the State 18 yrs. mos. ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 1506 E Pratt St

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel — DATE OF BURIAL, 10/21, 1920

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47429

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47429

43

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. St. Joseph's Hospital St.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary McCaulley (McCaulley) (26 m 18m)

(a) RESIDENCE. NO. 2000 Boone St. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	M. Widow

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Walter G. McCaulley

6 DATE OF BIRTH (month, day, and year) April 15, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Alexander Bond

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary -------

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss Irene B. McCaulley

(Address): 2000 Boone Street

15 Filed OCT 21 1920, 19 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21st 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1920, to Oct 21, 1920, that I last saw h[er] alive on Oct 21, 1920, and that death occurred, on the data stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Carcinoma of breast & Pleurisy (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 27, 1920.

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic

(Signed) J. A. Schenuit M. D.

(Address) St Joseph's Hosp. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	10/23, 1920
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D47430

HEALTH DEPARTMENT—CITY OF BALTIMORE

64D47430

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 214 Arlington Ave. ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Stafford

(a) RESIDENCE. No. 214 Arlington Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David Stafford

6 DATE OF BIRTH (month, day, and year): Feb. 2, 1871

7 AGE — Years: 49 — Months: 8 — Days: 16 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cambridge, Md.

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cambridge Md

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cambridge, Md.

14 Informant: Irvin Stafford

(Address) 214 Arlington Ave

15 Filed . 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/18/ 1920

17

I HEREBY CERTIFY, That I attended deceased from 10/8/, 19 20. to 10/18/, 19 20.

that I last saw her alive on 10/18/, 19 20.

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Total Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Apoplexy

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. B. Hawkins, M. D.

10/19/19 20 Address) 1216 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Oct 21 1920
20 UNDERTAKER	ADDRESS 78
Samuel Handley	W Biddle

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47431

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47431

CERTIFICATE OF DEATH.

REGISTERED NO. 37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Park Ave. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Smith.

(a) RESIDENCE. No. 1213 Park Ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lela Smith

6 DATE OF BIRTH (month, day, and year) Sept 24 188[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel plant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Athens Georgia

PARENTS

10 NAME OF FATHER Ned Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Athens Georgia

12 MAIDEN NAME OF MOTHER Fannie Gowens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Athens Georgia

14 Informant Lela Smith (Address) 1213 Park Ave.

15 Filed ... 19 20 ROBERT P. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/18 1920

17 I HEREBY CERTIFY, That I attended deceased from 10-11, 1920, to 10-18, 1920, that I last saw him alive on Oct. 18, 1920, and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Tertiary Syphilis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Wasserman

(Signed) William A. Harris, M. D.

, 19 (Address) 1200 Penna. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL Oct. 21 1920

20 UNDERTAKER Samuel Hemsley ADDRESS W. Balto

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 47432 HEALTH DEPARTMENT—CITY OF BALTIMORE D 47432

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 335 ½ Stricker ST.: 19 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas Rowe

(Residence in Baltimore: No. 335 ½ Stricker St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Blk

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April 16 (Month) (Day), 1919 (Year)

7-AGE, ~~~ yrs. 18 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work X
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Forman Rowe

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Bessie Doughty

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 335 Stricker St.

15- ROBERT B KRAUTER

Filed ..... 191.. Registrar.

OCT 21 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 20th (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16 1920, to Oct 19 1920, that I saw him alive on Oct 19 1920, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Meningitis

X (Duration) X yrs. X mos. 5 ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John F. Manges M. D.

Oct 21, 1920 (Address) 1002 E. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt Auburn et | DATE OF BURIAL, Oct 21, 1920

20-UNDERTAKER A. E. Brown & Son | ADDRESS 1011 N. Mond

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47433.

CERTIFICATE OF DEATH.

79 D47433

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 825 Plum ave ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie P. Murray

(Residence in Baltimore: No. 825 Plum ave. St.; 65 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, ? (Month) ? (Day), 1855 (Year)

7-AGE, 65 yrs. ? mos. ? ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... General House-work
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jacob Henry

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Julia Blake

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary D. Thompson

(Address) 1116 Brewer St

15-

OCT 21 1920 ROBERT B KRAUTER

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 19 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 17 1920, to Oct. 19 1920, that I saw h-r alive on Oct 19th 1920, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Hypertrophic

(Duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (Duration) yrs. mos. 3 ds.

(Signed) D. H. Thompson M. D.

10-21, 1920 (Address) 540 W Hull St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn et — DATE OF BURIAL, Oct 22d, 1920

20-UNDERTAKER H. L. Brown and Son — ADDRESS 108 W. Montgomery

Spec.—8-24-14—M. & T.—2000 Blks.

D 47434

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47434

50

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 Gaunt Lane, St.; 20 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Adolph Graf

(Residence in Baltimore: No. 312 Gaunt Lane St.; 59 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept 15, 1861
(Month) (Day) (Year)

7-AGE, 59 yrs. 1 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Broom Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER. Valentine Graf

11-BIRTHPLACE OF FATHER (State or Country). Penna Dutch

12-MAIDEN NAME OF MOTHER Wilhemina Bruech

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elena Graf

(Address) 312 Gaunt Lane

15- OCT 21 1920 Filed....., 191.. ROBERT B KRAUTER Burial Permit Clerk.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 18, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 14 1920, to Oct 18 1920, that I saw h[illegible] alive on Oct 18 1920, and that death occurred, on the date stated above, at 2. P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

..... (Duration) yrs. mos. ds.

(Signed) ..... M. D.

10 20, 1920 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	Oct 21, 1920
20-UNDERTAKER	ADDRESS
H B Hilgenhurst	233 E Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47435 HEALTH DEPARTMENT—CITY OF BALTIMORE D47435

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2019 Keyser ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Chambers

(a) RESIDENCE. No. 2019 Keyser ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) March 29, 1920

7 AGE — Years	6 Months	Days	If LESS than 1 day, hrs. or min.
		—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 800

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) born in Balt

PARENTS

10 NAME OF FATHER Robert Chambers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Pearl Sumner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) born in Va

14 Informant (Address) Father Robert Chambers 2019 Keyser st

15 Filed OCT 21 1920 19.... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1920, to Oct. 20, 1920

that I last saw her alive on Oct. 19, 1920,

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Catarrh 14

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno C Stinson M. D.

(Address) 1525 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Oct-21, 1920
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	1725 Ashland Ave

THIS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0447436 HEALTH DEPARTMENT—CITY OF BALTIMORE 0447436

CERTIFICATE OF DEATH. 9-891

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Feimer

(a) RESIDENCE. NO. 1413 E Clement ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. 0 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4-1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Nicholas Feimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Susa Hedervari

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary.

14 Informant Susa Feimer. (Address) 1413 E. Clement St

15 Filed OCT 21 1920 ... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1920.

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1920, to Oct 21, 1920, that I last saw him alive on Oct 21, 1920 and that death occurred, on the date stated above, at 7:15 a m.

The CAUSE OF DEATH* was as follows:

Laryngeal diptheria

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No Direct laryngoscopy

What test confirmed diagnosis? Pos. diptheria culture

(Signed) B. MacGowan, M. D.

(Address) Sydenham Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem Brooklyn	Oct 21 1920
20 UNDERTAKER	ADDRESS
Margaret T. Flynn	1422 Light St

Oct 21 1920

THIS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47437 HEALTH DEPARTMENT—CITY OF BALTIMORE D47437

CERTIFICATE OF DEATH. X 28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3425 Chestnut Ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin H. Chaney

(a) RESIDENCE. NO. 3425 Chestnut Ave WARD. Laurel Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma M Chaney

6 DATE OF BIRTH (month, day, and year) Feb 3 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Molder. 847

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel Chaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Sanahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma Chaney

(Address) 3425 Chestnut Ave

15 Filed OCT 21 1920 ROBERT B FLEXNER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1920, to Oct. 19, 1920, that I last saw him alive on Oct. 17, 1920, and that death occurred, on the date stated above, at 5.15 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 12 mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3059 Stricklands Ct Baltimore Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam.

(Signed) W. W. Smith, M. D.

Oct 19 20 (Address) 3429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md	Oct 22 1920
20 UNDERTAKER	ADDRESS
Ehenowetht Son	Chestnut Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 47438 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 47438

CERTIFICATE OF DEATH. 1920

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St Josephs Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Popielek

(a) RESIDENCE. NO. 604 S. Ann ST., 2nd WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 10-1899.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Stuff Yard

(b) General natore of Industry, business, or establishment in which employed (or employer) Balto Dry Dock Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Stanislaus Popielek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Filipowicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Polielek (Address) 604 S. Anna St.

15 Filed ....., 19.... Registrar

OCT 21 1920 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 19 20, to Oct 21, 19 20, that I last saw him alive on Oct 21, 19 20, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Frank C Marino, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	Oct 23rd 1920
20 UNDERTAKER W F. Sadowski.	ADDRESS 905 S. Ann

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D. 47439 HEALTH DEPARTMENT—CITY OF BALTIMORE D 47439

CERTIFICATE OF DEATH. X 74

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Partain

(a) RESIDENCE. NO. Lawrenceburg, Tenn ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nina Partain

6 DATE OF BIRTH (month, day, and year) Sept 20-1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER B N Partain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Elizabeth Bone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Hospital Record
(Address) J H H

15 Filed OCT 21 1920 16 Robert P. Harrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20th 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 9th 1920 to Oct 20th 1920 that I last saw him alive on Oct 20th 1920 and that death occurred, on the date stated above, at 1050 A. m.

The CAUSE OF DEATH* was as follows:

Brain tumor in cerebellar region

(duration) 4 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Tennessee

Did an operation precede death? Yes Date of 9-11-20 10-13-20

Was there an autopsy? Yes

What test confirmed diagnosis? Post Mortem Examination

(Signed) H. E. Cushing, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bear Creek Alabama	Oct 21 1920
20 UNDERTAKER	ADDRESS
John O Mitchell	1501 W. Fayette St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47440

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47440

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. St.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Crist

(a) RESIDENCE. No. 2211 Portugal ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Morton Crist

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Eliz. Murphy

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant
(Address)

15 Filed Oct 21 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1920, to Oct. 20, 1920, that I last saw him alive on Oct 20, 1920, and that death occurred, on the date stated above, at 1.00 a m.

The CAUSE OF DEATH* was as follows:

Atelectasis Neonatorum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) J B. Bronushas M. D.

10-20. 1920 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	
20 UNDERTAKER	ADDRESS

Commissioner Health.

OCT 21 1920

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47441 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47441

CERTIFICATE OF DEATH.

92

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 Mosher St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Hillie Chapman Powell.

(Residence in Baltimore: No. 1225 Mosher St St.; 37 yrs., ✓ mos. ✓ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, January 7, 1883.
(Month) (Day) (Year)

7-AGE, 37 yrs. 9 mos. 14 ds. If LESS than 1 day, ✓ hrs. or ✓ min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper.
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Piedmont W. Va.

PARENTS.

10-NAME OF FATHER, Thos. C. Powell.

11-BIRTHPLACE OF FATHER (State or Country), West Virginia

12-MAIDEN NAME OF MOTHER Jane A. McClung.

13-BIRTHPLACE OF MOTHER (State or Country), Staunton Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stephens D. Powell

(Address) 1538 Harlem Ave

15- Filed OCT 21 1920, 191.....
Robert P. Harrison,
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 21, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 14 1920, to Oct 21 1920, that I saw her alive on Oct 20 1920; and that death occurred, on the date stated above, at 4:00 a.m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia Acute.

(Duration) ✓ yrs. ✓ mos. 7 ds.

CONTRIBUTORY (Secondary) Nephritis —

(Duration) ✓ yrs. 2 mos. ✓ ds.

(Signed) Geo. E. Shannon M. D.

Oct 21, 1920 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct 23, 1920

20-UNDERTAKER W. J. Tackney — ADDRESS Walbrook

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47442 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47442

82

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 W. Mulberry St. 19 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Crotty

(a) RESIDENCE. No. 150 W. Mulberry St. .... Ward. ....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. .... mos. .... ds. How long in U. S., if of foreign birth? 30 yrs. .... mos. .... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F. Crotty

6 DATE OF BIRTH (month, day, and year) March 12 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 086

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Delia Dockery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Patrick J. Kelly

(Address) Buskirk Ave Towson

15 Filed Oct 21 1920, 19 Robert T. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1920, to Oct 21, 1920, that I last saw h[illegible] alive on Oct 21, 1920, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) ? yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Exam.

(Signed) B.O'Kelly, M. D.

10/21, 1920 Address) 100 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Oct 23 1920

20 UNDERTAKER Jos. B. Cook — ADDRESS 1003 Baltimore

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 47443

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 47443

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1732 W. Lexington St. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Renner

(a) RESIDENCE. NO. 1732 W. Lexington St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced

5a If ~~married, widowed,~~ or divorced (~~wife~~) of Charles Walters

6 DATE OF BIRTH (month, day, and year) June 1, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George L. Renner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Justina Wagner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Josephine L. Abell
(Address) 1732 W. Lexington St.

15 Filed OCT 21 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20, 19 20

17 I HEREBY CERTIFY, That I attended deceased from June 15, 19 20, to Oct 20th, 19 20.
that I last saw her alive on Oct 19th, 19 20,
and that death occurred, on the date stated above, at 7.45 a m.
The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach
about 1 yrs. — mos. — ds.
(duration)

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Presence of a tumor + general symptoms. W. A. Fair, M. D.
(Signed)
Oct 21 1920 (Address) 17 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Oct 22 20
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W Balto

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47444 HEALTH DEPARTMENT—CITY OF BALTIMORE. 1047444

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1503 E Lafayette St. Ave 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Doris Becker

(a) RESIDENCE. NO. 1503 E Lafayette ST. Ave, WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 8 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Walter L. Becker

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Heinke

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mother (Address) 1503 E Lafayette Ave

15 Filed OCT 22 1920 16 Registrar ROBERT E. SLANTER

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1920, to Oct 19, 1920, that I last saw h[er] alive on Oct 19, 1920, and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)* Indigestion (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. J. Russell M. D.

(Address) 801 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 21 1920

20 UNDERTAKER Edward K Conklin ADDRESS 524 E Eager

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D47445 HEALTH DEPARTMENT—CITY OF BALTIMORE D47445

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 S Harris alley ST.; 1 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Zomunsky

(Residence in Baltimore: No. 915 S Harris alley St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W	Single

6-DATE OF BIRTH, Nov 1 (Month) (Day), 1919 (Year)

7-AGE, yrs. 1 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Edward Zomunsky

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Phronie Zawodny

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ed Mackiewicz

(Address) 720 S Dallas St

15- OCT 22 1920 ROBERT B KRAUTER

Filed ....., 191.... Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 21 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 14 1920, to Oct 21 1920, that I saw him alive on Oct 21 1920, and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

Gastro intestinal intoxication

Colon (Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Edema Glottidis

Passive Pneumonia (Duration) yrs. mos. 3 ds.

(Signed) L. J. Kaminsky M. D.

Oct 21, 1920 (Address) 3 W 35 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary Cem — DATE OF BURIAL, Oct 23, 1920

20-UNDERTAKER, Stephen J Szalkowski — ADDRESS 1100 S Kenwood ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47446 HEALTH DEPARTMENT—CITY OF BALTIMORE D47446

CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 E Lanvard. St.: 3 Ward) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Feldman

(a) RESIDENCE. No. 1012 E Lanvard St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	110	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant D. Feldman New York (Address)

15 Filed OCT 22 1920 ROBERT P. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1920

17 I HEREBY CERTIFY, That I attended deceased from 7-4- 1920, to 10-10- 1920, that I last saw h in alive on 10-10- 1920, and that death occurred, on the date stated above, at 129 m.

The CAUSE OF DEATH* was as follows: Carcinoma of stomach.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Senility.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Place of death

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs.

(Signed) Dr. C. Walzoff M. D.

10/21, 1920 (Address) 116 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Blaine Rd Cemet

DATE OF BURIAL Oct 22 1920

20 UNDERTAKER Max Jurman

ADDRESS 1127 E Balto St

TION is very important. See instructions on back of certificates.

D47447 HEALTH DEPARTMENT—CITY OF BALTIMORE D47447

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hebrew Hospital St.) (WARD) REGISTERED No. C 172

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Dean.

(Residence in Baltimore: No. Hebrew Hospital St.: 40 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, ..., 1855
(Month) (Day) (Year)

7-AGE, 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Orderly
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Schmidt

(Address) Walnut Ave Overlea

15- OCT 22 1920 ROBERT E KRAUTER

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatism: fell

..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. D. Mosley M. D.
(Coroner)

11-22-, 191.2 (Address) 24 S. Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, 1st Evangelical Bom | DATE OF BURIAL, Oct 22 1920

20-UNDERTAKER H. Lander Sons | ADDRESS 1210 Park Ave

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D47448

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47448

CERTIFICATE OF DEATH.

103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 E. Federal ST.; 9 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert J Simmons

(Residence in Baltimore: No. 1407 E Federal St St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April 5, 1849.
(Month) (Day) (Year)

7-AGE, 71 yrs. 6 mos. 15 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: telegraph lineman repair work
(b) General nature of industry, business, or establishment in which employed (or employer): U S Telegraph Co.

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Richard Simmons

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Cathrin Conor

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs E Dietz Sister

(Address) 1405 E Federal St

15-

Filed OCT 22 1920, 191.... ROBERT F. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 20, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January, 1918, to October 20 1920, that I saw h.. alive on October 20 1920, and that death occurred, on the date stated above, at 11:15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Gastritis

about

(Duration) 5 yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) .... yrs. 2 mos. .... ds.

(Signed) H Nanny Nusbaum M. D.

Oct 22 1920 (Address) 1116 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemetery — DATE OF BURIAL, Oct 23d 1920

20-UNDERTAKER Geo Schilling & Sons — ADDRESS 1126 E Monument St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47449

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47449

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1232 E Monument ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aquilla H. Gosnell

(a) RESIDENCE. No. 1232 E Monument ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? — yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 22nd 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machenist

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Richard Gosnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna R Harryman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Lavinia King

(Address) 1232 E Monument St

15 Filed OCT 22 1920 ROBERT F. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20th 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1919, to Oct 20, 1920, that I last saw h[illegible] alive on Oct 20, 19..., and that death occurred, on the date stated above, at 11.10 P. m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(duration) yrs. 10 mos. — ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) A W Wegefarth M. D.

, 19 (Address) 2031 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Oct 28th 1920
20 UNDERTAKER George Schilling & Sons	ADDRESS 1126 E Monument St

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

047450

HEALTH DEPARTMENT—CITY OF BALTIMORE

047450

CERTIFICATE OF DEATH.

43

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 W. Lombard ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Ida Martin.

(Residence in Baltimore: No. 1109 W. Lombard St St.; 4/4 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White.	Widow

6-DATE OF BIRTH, December 25, 1862
(Month) (Day) (Year)

7-AGE, 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Jos. Barnett.

11-BIRTHPLACE OF FATHER (State or Country) Balto.

12-MAIDEN NAME OF MOTHER Annie B. Legg.

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Martin

(Address) 1109 W. Lombard st

15-

OCT 22 1920

Filed ..... 191.. BURIAL PERMIT (Illegible)

ROBERT J. KRAUTER

Registrar.

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 20., 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1 1919, to Oct. 20. 1920, that I saw h alive on Oct. 20. 1920 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast.

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. Morton M. D.

10/22, 1920 (Address) 888 W. Lombard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Oct. 23., 1920

20-UNDERTAKER	ADDRESS
John Fields	1200 W Lombard st

D47451 HEALTH DEPARTMENT—CITY OF BALTIMORE D47451

CERTIFICATE OF DEATH.

103

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 1108 McCulloh ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Bell

(Residence in Baltimore: No. 1108 McCulloh St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): married

6-DATE OF BIRTH, January 3, 1894
(Month) (Day) (Year)

7-AGE, 26 yrs. 9 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Tin Plate mill

9-BIRTHPLACE, (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: Barton Bell

11-BIRTHPLACE OF FATHER (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: Catherine Smith

13-BIRTHPLACE OF MOTHER (State or Country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Theodore Bell

(Address) 1108 McCulloh St

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart (45 minutes)
(Duration) yrs. mon. ds.

CONTRIBUTORY (Secondary) Acute Indigestion 2 hrs.
(Duration) yrs. mos. ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)

Oct 20, 1920 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cosnova Va Fauquier Co

DATE OF BURIAL, Oct 23, 1920

20-UNDERTAKER John H Ouent

ADDRESS 1738 Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47452 HEALTH DEPARTMENT—CITY OF BALTIMORE D47452

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal tuberculosis Hospital ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Garrison Wright

(a) RESIDENCE. No. 611 Archer st. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: William H. Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Nancy Hackett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records
(Address): M.T.H.

15 Date: OCT 22 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 21, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1920, to Oct. 21, 1920, that I last saw him alive on Oct. 20, 1920, and that death occurred, on the date stated above, at 9.25 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed) L.J. Argoy M. D.

10-21-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Oct 23 1920
20 UNDERTAKER: John A. Tradum	ADDRESS: West End

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

1047453 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047453

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Aged Mens Home (St.:) 19 (Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas Wesley Marlin

(a) RESIDENCE. No. 1400 W Lexington St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Wht	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	93			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Man 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ellicott City Md

PARENTS

10 NAME OF FATHER Jos Marlin

11 BIRTHPLACE OF FATHER (city or town) Balto Co (State or country) Md

12 MAIDEN NAME OF MOTHER Hannah Emmart

13 BIRTHPLACE OF MOTHER (city or town) Balto Co (State or country) Md

14 Informant H. W Dillaway (Address) Matron

15 Filed OCT 22 1920, 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1920, to Oct 21, 1920, that I last saw h alive on Oct 21, 1920, and that death occurred, on the date stated above, at 10 45 A.M.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Debility (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

, 19 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	Oct 23 1920

20 UNDERTAKER George J Smith ADDRESS 1000 W Fayette

TION is very important. See instructions on back of certificates.

OCT 22 1920 ROBERT J. KRAUTER Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Blks.

0647454 HEALTH DEPARTMENT—CITY OF BALTIMORE 0647454

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3031 Westwood Av St.? 15 62 WARD) REGISTERED NO. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna B. Joyce

(Residence in Baltimore: No. 3031 Westwood Av St.? 74 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, August (Month) 30th (Day), 1846 (Year)

7-AGE, 74 yrs. 2 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Hagerstown Md

PARENTS.

10-NAME OF FATHER, John R. Sweary

11-BIRTHPLACE OF FATHER (State or Country), Hagerstown Md

12-MAIDEN NAME OF MOTHER Elizabeth Eakle

13-BIRTHPLACE OF MOTHER (State or Country), Funkstown Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eleanor Falls

(Address) 3031 Westwood Ave

15-

Filed OCT 22 1920, 191.... ROBERT P. BRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 20th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15th 1920, to Oct 20th 1920, that I saw h r alive on Oct 20th 1920, and that death occurred, on the date stated above, at 7 25 P. m.

The CAUSE OF DEATH* was as follows: Progressive Pernicious Anemia

(Duration) 3 yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) .... yrs. .... mos. .... ds.

(Signed) Wm H Welch M. D.

Oct 21st 1920 (Address) 6 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Hill Cemetery Higgerstown Md. DATE OF BURIAL, OCT. 22, 1920

20-UNDERTAKER George J. Smith ADDRESS 1201 E. Fayette St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D947455 HEALTH DEPARTMENT—CITY OF BALTIMORE D947455

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 N. Mount - St.; 19 Ward) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. Hamilton

(Residence in Baltimore: No. 821 N. Mount - St.; 10 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Oct 15, 1852 (Month) (Day) (Year)

7-AGE, 68 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER, James Hamilton

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Jane S. Kelly

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grace O'Brien

(Address) 231 N. Smallwood St.

15- OCT 22 1920 ROBERT B. KRAUTER

Filed....., 191.... Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 21, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 19 1920, to Oct 21 1920, that I saw h[illegible] alive on Oct 20 1920, and that death occurred, on the date stated above, at 2 45 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocardial degeneration.

(Duration) yrs. mos. 2 ds.

(Signed) M Brennan Lord M. D.

Oct. 21, 1920. (Address) 626 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Oct. 23, 1920
20-UNDERTAKER George J. Smith	ADDRESS Fayette

Important. See instructions on back of certificate.

Cahn.

Spec.—8-24-14—M. & T.—2000 Blks.

1947456 HEALTH DEPARTMENT—CITY OF BALTIMORE 1947456

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Emory Gen. Hosp. REGISTERED No. C

CITY OF BALTIMORE: (No. Frederick Road ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Daniel Cahn

(Residence in Baltimore: No. 3618 Parkhurst Rd St.: 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, January 10th, 1848
(Month) (Day) (Year)

7-AGE, 72 yrs. 9 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, Bernard Raft

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alfred J. Cannon M.D.

(Address) Athol Frederick Road

15- OCT 22 1920 ROBERT B KRAUTER
Filed....., 191..Registrar.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 22, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 12 1911, to Oct 22 1920, that I saw h e alive on Oct 21 1920, and that death occurred, on the date stated above, at 8-46 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(Duration) yrs. mos. ds.

(Signed) Alfred J. Cannon M. D.

Oct. 22, 1920. (Address) Athol Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. 9 mos. 10 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Baltimore

Former or usual residence 3618 Parkhurst Rd Baltimore

19-PLACE OF BURIAL OR REMOVAL, Adath Israel DATE OF BURIAL, Oct 24, 1920

20-UNDERTAKER David Sondheim ADDRESS N & W Mulberry

Important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1047457 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047457

CERTIFICATE OF DEATH.

REGISTERED No. C 167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin St Hospital St.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Jorden

(Residence in Baltimore: No. English Consulate Balto. C. St.; yrs., 2 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word) Single

6-DATE OF BIRTH, April 22, 1895 (Month) (Day) (Year)

7-AGE, 25 yrs. 5 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Nurse
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, John Jorden

11-BIRTHPLACE OF FATHER (State or Country), Hungaria

12-MAIDEN NAME OF MOTHER Elizabeth Mwos

13-BIRTHPLACE OF MOTHER (State or Country), Hungaria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Jorden

(Address) English Consulate

15- OCT 22 1920 ROBERT F KRAUTER Registrar.
Filed....., 191.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 21, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

30 Burns over Greater part of body by falling in burning Accident

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Shock

(Duration) .....yrs. mos. 1/2 ds.

(Signed) James M. Kenton M. D. (Coroner.)

Oct 22, 1920 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....
English Consulate

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem. DATE OF BURIAL, Oct 23, 1920

20-UNDERTAKER Mrs John H Teufel ADDRESS 24 W Fayette St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47458

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D47458

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10 WARD)

2-FULL NAME Mary Barnes.

(a) RESIDENCE. No. Preston & Valley Sts ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General noture of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Havre de grace Maryland

PARENTS

10 NAME OF FATHER Wm Barnes,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Donahue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sister Florence

(Address) Preston & Valley Sts

15 Filed OCT 22 1920 ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1920

17

I HEREBY CERTIFY, That I attended deceased from No record 19 , to 19 , that I last saw h[er] alive on Oct 20 , 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH was as follows:

Acute bronchitis

10 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

Oct 22, 1920 (Address) 1133 Valley St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Oct 22 1920

20 UNDERTAKER H. C. Wickefeld ADDRESS 914 Gilmor

THION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 47459

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47459

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 N Bond ST.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Krupchik or Kessler

(Residence in Baltimore: No. 802 N. Bond St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March, 1875
(Month) (Day) (Year)

7-AGE, 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Baltimore St.

15-

Filed OCT 22 1920, 191...

ROBERT B. LEAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 22, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 17 1920, to Oct 17 1920, that I saw him alive on Oct 20 1920, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Coronary and Cerebral disease

Carcinoma Esophagus

Angina pectoris (Duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Sudden death in an anginal attack

(Duration) yrs. mos. ds.

(Signed) Frank R. Smith M. D.

OCT 22, 1920 (Address) 927 N. Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Shehrem Rosedale — DATE OF BURIAL, 10-27-, 1920

20-UNDERTAKER Jack Lewis — ADDRESS 1411 E Balto St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47460

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47460

CERTIFICATE OF DEATH.

REGISTERED NO. 15-91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1600 W North Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M Cook

(a) RESIDENCE NO. 1600 W. North Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Eugene Cook.

6 DATE OF BIRTH (month, day, and year) Aug 18 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Markley

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mamie Syfer
(Address) 1600 W. North Ave

15 Filed OCT 22 1920, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1920, to Oct. 20, 1920, that I last saw her alive on Oct. 20, 1920, and that death occurred, on the date stated above, at 4 15 P m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ?

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J Frederick Lutz, M. D.

Oct 22 1920 (Address) 1140 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Oct 23 1920

20 UNDERTAKER Josiah Syfer

ADDRESS 1600 W. North Ave

Burial Permit

TION is very important. See instructions on back of certificates.

at it may be properly classified. Exact statement of OCCUPA-

PHYSICIANS should state

Powers.

Spec.—6-9-19—H. P. Co.—1000 Bks.

2047461 HEALTH DEPARTMENT—CITY OF BALTIMORE 2047461

CERTIFICATE OF DEATH. X 79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Myer Hook. St.: 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Thos. Powers

(a) RESIDENCE. No. Ellicott City, Md St.. Ward. Ellicott City

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

006

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Patrick Powers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Alice Welch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Matthew Powers Ellicott City, Md.

15 Filed OCT 22 1920 19 ROBERT E. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/20 1920

17 I HEREBY CERTIFY, That I attended deceased from 10/16 1920, to 10/20 1920, that I last saw him alive on 10/20 1920, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Simm O. Ridgely, M. D

1921 1924 (Address) Myer Hook.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New E. St. Paul's Howard Co.	Oct. 25 1920
20 UNDERTAKER	ADDRESS
Easton Sons	Ellicott City

TION is very important. See instructions on back of certificates.

D47462 HEALTH DEPARTMENT—CITY OF BALTIMORE D47746

50

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE (No. 2905 Clifton Ave ST.; 15th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Sarah Ball.

(Residence in Baltimore: No. 2905 Clifton Ave St.; 63 yrs. 4 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX F | 4-COLOR OR RACE W. | 5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

6-DATE OF BIRTH June (Month) 12 (Day), 1857 (Year)

7-AGE 63 yrs. 4 mos. 7 ds. | If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country) Baltimore Md.

PARENTS

10-NAME OF FATHER Jacob Langheimer

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Mathilda Goldbacher

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Ball

(Address) 2905 Clifton Ave.

15- Filed OCT 22 1920, 191.....

ROBERT E KRAUTER
Burial Permit Clerk
REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH October (Month) 19 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from February, 1920, to October 1920, that I saw her alive on Oct 19, 1920, and that death occurred, on the date stated above, at 10.55 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 12 yrs. ... mos. ... ds

Contributory (SECONDARY)* Acute Angina Pectoris

(Duration) yrs. 2 mos. ... ds.

(Signed) W. McKelvey M. D.

Oct 20, 1920 (Address) St Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. | In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Hebrew Friendship | DATE OF BURIAL Oct 22, 1920

20-UNDERTAKER J. Ahrens & Co | ADDRESS 1611 Madison

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

143 034 D47463. D47463

CERTIFICATE OF DEATH.

X 91

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: NO. Johns Hopkins Hosp ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexandra McKnight.

(a) RESIDENCE. NO. 3926 Worth St. Dallas Texas WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20. 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ? 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dallas
(State or country) Texas

PARENTS

10 NAME OF FATHER Alexander McKnight

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Texas

12 MAIDEN NAME OF MOTHER Ada Chambers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Texas

14 Informant
(Address)

15 Filed OCT 22 1920 ROBERT E. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1920, to Oct 21, 1920, that I last saw h[er] alive on Oct 21, 1920, and that death occurred, on the date stated above, at 11.0 p m.

The CAUSE OF DEATH* was as follows: (Epilepsy —
Stroke — post operative
intracranial blood extravasation —
probable meningitis
(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Intracranial hemorrhage
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Texas -

Did an operation precede death? Yes - Date of Oct 11 '20

Was there an autopsy? Yes -

What test confirmed diagnosis?

(Signed) Emile Holman M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dallas Texas	Oct — 19
20 UNDERTAKER	ADDRESS
Joseph Abrens	221 Bway

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47464

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47464

CERTIFICATE OF DEATH.

8-091

REGISTERED NO. 6

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1624 Mulliken ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Wilson

(a) RESIDENCE. NO. 1624 Mulliken ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Dec 31st 1919

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va and

12 MAIDEN NAME OF MOTHER Emma

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Chas Wilson
(Address) 1624 Mulliken St.

15 Filed OCT 22 1920 ROBERT S. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 21, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1920, to Oct. 21, 1920.

that I last saw he alive on Oct. 21, 1920.

and that death occurred, on the date stated above, at 8:20 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

Signed Jas C Robinson M. D.

10/22 1920 (Address) 1538 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Auburn Cem.	Oct 25th 1920

20 UNDERTAKER ADDRESS

Harry A. Vodery 1725 Orleans St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047465 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047465

CERTIFICATE OF DEATH. 92

1-PLACE OF DEATH St Agnes Hospital Wilkins ave

CITY OF BALTIMORE: (No. ~~925~~ Columbia ave St.; 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Russel Stalling

(a) RESIDENCE. No..... 925 Columbia ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPA-TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) May 5th 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Ed. Stalling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Fay ~~Vaughn~~

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo Knell
(Address) 917 Columbia Ave

15 Filed OCT 22 1920 ROBERT B [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1920, to Oct 21, 1920

that I last saw him alive on Oct 21, 1920.

and that death occurred, on the date stated above, at 5:15 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) W. M. Craig, M. D.

, 19 (Address) St Agnes Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Oct 23 1920

20 UNDERTAKER: Knell & Sons — ADDRESS: 1729 W Pratt St

Laura Merson

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47466 ✓

CERTIFICATE OF DEATH.

119 D47466

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Merc Hosp. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Laura Merson

(a) RESIDENCE. NO. 812 Woodward ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan Merson

6 DATE OF BIRTH (month, day, and year) 8/25/78

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Laurel-Md

PARENTS

10 NAME OF FATHER Silas R. Deaton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Nathan W. Merson (Address) 812 Woodward Street

15 Filed OCT 22 1920, 19 Burial Permit Issued Registrar

Via Motor Hearse.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1920

17 I HEREBY CERTIFY, That I attended deceased from 10/12, 19 20, to 10/21, 19 20, that I last saw h alive on 10/21, 19 20, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis over

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs.

(duration) yrs. mos. ds.

18 Where was disease contracted ? If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lewis O. Ridgely, M. D.

10/20 1920 (Address) Merc Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel - Md	Oct. 23 1920
20 UNDERTAKER William Cook	ADDRESS 502 E. Natt ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Could find no other abnormal condition. Primary acute nephritis

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47467

CERTIFICATE OF DEATH.

109 D 47467

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1560 Clifton ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Washington Crooks

(a) RESIDENCE. No. 1560 Clifton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wht	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Constantine V Crooks

6 DATE OF BIRTH (month, day, and year) May 27 / 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ret. Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

14 Informant Mrs. Florence B. Gunther

(Address) 1560 Clifton St

15 Filed OCT 22 1920 ROBERT F KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21st 1920

17 I HEREBY CERTIFY, That I attended deceased from about One Year, 19..., to ..., 19...

that I last saw him alive on Oct 20, 1920,

and that death occurred, on the date stated above, at 9.40 A m.

The CAUSE OF DEATH* was as follows:

Infirmities of age, complicated with large Hernia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gradual Weakening

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) P. H. Smith, M. D.

Oct 21 1920 (Address) 605 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Rosyln Md	Oct 23 1920
20 UNDERTAKER	ADDRESS
William Cook	507 E North Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D47468

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47468

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Worick

(a) RESIDENCE. No. 427 Whitridge Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Worick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Elizabeth Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed OCT 22 1920 ROBERT B. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22, 1920

17 I HEREBY CERTIFY, That I attended deceased from September 28, 1920 to October 22, 1920, that I last saw him alive on October 21, 1920, and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of right leg including fibula & tibia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia & Cachexia (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Holden, M. D.

(Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Pond	Oct 25- 1920
20 UNDERTAKER	ADDRESS
William Cook	502 S. Hall ave.

CAUTION is very important. See instructions on back of certificates. Use property classified. Exact statement of cause in plain terms, so that it may be properly

Spec.—6-9-19—H. P. Co.—1000 Bks.

0947469 HEALTH DEPARTMENT—CITY OF BALTIMORE 0947469

81

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Little Sisters of the Poor; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Hoffsnyder,

(a) RESIDENCE. No. Preston & Valley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Hoffsnyder

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Blottberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Collet.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sister Florence,
(Address) Preston & Valley Sts.

15 Filed OCT 22 1920 ROBERT F. LEADER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1920

17 I HEREBY CERTIFY, That I attended deceased from No record, 19, to, 19,
that I last saw h[illegible] alive on Oct 21, 1920,
and that death occurred, on the date stated above, at 1.15 a m.
The CAUSE OF DEATH* was as follows:

Arterio sclerosis
Unknown (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Warner, M. D.
Oct 24, 1920 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Co	Oct 23 - 1920
20 UNDERTAKER William Cook	ADDRESS 502 E. Hoff Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.47470 ✓ 20.47470

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry E. Hoffman

(a) RESIDENCE. No. 1936 Holland St. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 04

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John T. Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ellen Keyes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Hospital Records (Address) H.T.H.

15 Filed OCT 22 1920, 19 ... Registrar: Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1920, to Oct. 20, 1920, that I last saw him alive on Oct. 19, 1920, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. insputum, X-ray

(Signed) L. J. Hayes, M. D.

10-20-20, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

UNIVERSITY OF MARYLAND

JOHNS HOPKINS

DATE OF BURIAL OCT 22 1920

20 UNDERTAKER: Commissioner Health, By ...

ADDRESS

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47471

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47471

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital. ST. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mark McClellan

(a) RESIDENCE. No. Unknown ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1855(?)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Unknown 65(?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed OCT 22 1920, 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 19, 1920

17 I HEREBY CERTIFY, That I attended deceased from October 18, 1920 to October 19 1920, that I last saw him alive on October 18, 1920, and that death occurred, on the date stated above, at 12:45 A m.

The CAUSE OF DEATH* was as follows:

Acute myocardial insufficiency.

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No. especial test.

(Signed) Netterman., M. D.

10/19/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND.	19

20 UNDERTAKER Commissioner Health, Wm. H. WOODALL

ADDRESS OCT 22 1920

CAUSE OF DEATH to be properly classified, Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47472 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47472

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 604 W. Hoffman, ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Ann Mason

(a) RESIDENCE. No. 604 W. Hoffman ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Walter Mason

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74.	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James W. Crowley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know.

12 MAIDEN NAME OF MOTHER Charlott Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jos. Mason

(Address) 604 W. Hoffman.

15 Filed OCT 22 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-21- 1920

17

I HEREBY CERTIFY, That I attended deceased from 9-15-, 1918, to 10-21-, 1920

that I last saw her alive on 10-21-, 1920

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvulitis

Indefinate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) Indefinate yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. H. Hargill, M. D.

10-21-1920 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	Oct 25 1920

20 UNDERTAKER Felix B. Pyle. ADDRESS 1026 Mulberry St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47473 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47473

CERTIFICATE OF DEATH. 39

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 616 N Castle ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G. Haffner

(a) RESIDENCE. No. 2020 Monument St. 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice A Haffner

6 DATE OF BIRTH (month, day, and year) Jan 14 1861

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jailer 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER dont Known

11 BIRTHPLACE OF FATHER (city or town) — (State or country) —

12 MAIDEN NAME OF MOTHER dont Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Alice A Haffner (Address) 2020 Monument

15 Filed OCT 22 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1, 1920, to Oct. 21, 1920, that I last saw him alive on Oct. 21, 1920, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the tongue

(duration) 2 yrs. + mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? -microscopic

(Signed) Edward Horak, M. D.

, 19 (Address) 821 N. Patt. Pk. av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem	Oct 27 1920
20 UNDERTAKER	ADDRESS
John Herwig & Co	2008 Orleans

D.47474 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47474

CERTIFICATE OF DEATH.

REGISTERED No. C 184

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin St. Hospital St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Trager

(Residence in Baltimore: No. 1524 Clifton ave St.; 22 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, December (Month) 13 (Day), 1897 (Year)

7-AGE, 22 yrs. 10 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 037
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, Oscar Kellner,

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Henriette Burtzluff,

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earl J. Trager.

(Address) 1524 Clifton Ave

15- Robert P. Harrison,

Filed OCT 22 1920, 191 Burial Permit Cle... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicaemia following abortion Self Induced

(Duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary) Septic Intoxication

(Duration) ... yrs. ... mos. 15 ds.

(Signed) James M. Fenlon M. D. (Coroner)

Oct 22 1920 (Address) 701 E. Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS) At place of death ...yrs. ...mos. 13 ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? 1524 Clifton Ave

Former or usual residence 1524 Clifton Ave

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge

DATE OF BURIAL, Oct. 25, 1920

20-UNDERTAKER Geo W Little

ADDRESS 531 N. Fremont Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.47475 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.47475

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 957 N. Collington Ave WARD 7) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G. Butler

(a) RESIDENCE. No. 957 N. Collington Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 4 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Annie M. Butler

6 DATE OF BIRTH (month, day, and year) May 29/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Potter 086

(b) General nature of industry, business, or establishment in which employed (or employer) Crockery Ware

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Annie M. Butler

(Address) 957 N. Collington Ave

15 Filed OCT 22 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21st 1920

17 I HEREBY CERTIFY, That I attended deceased from May, 1920, to Oct 21, 1920, that I last saw h im alive on Oct 17 1920, and that death occurred, on the date stated above, at 3.15 A m

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. Boden, M. D.

, 19 (Address) 1904 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct 23 1920
20 UNDERTAKER Philip Herring	ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 47474

CERTIFICATE OF DEATH.

D. 47474

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 304 E Chase St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Louis Haines

(Residence in Baltimore: No. 304 E. Chase St.; 2 yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Dec 24, 1855 (Month) (Day) (Year)

7-AGE, 65 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Labor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) New Windsor Md

PARENTS.

10-NAME OF FATHER, Moses Haines

11-BIRTHPLACE OF FATHER (State or Country) Linwood Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country) Linwood Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Moses E B Haines

(Address) 304 E. Chase St

15-

Filed....., 191.... Registrar.

[Burial Permit Clerk]

Robert P. Harrison,

OCT 23 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 22, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Oct 22 1920, that I saw h alive on Oct 22 1920, and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) D. D. S. yrs. mos. ds.

(Signed) Luigi D DiStefano M. D.

Oct 22, 192.. (Address) 407 N Exeter St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Windsor Carroll Co. Md

DATE OF BURIAL, Oct 25, 191...

20-UNDERTAKER H Bankard & Son

ADDRESS Westminster Md

important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D.47477

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47477

CERTIFICATE OF DEATH.

6-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 N. Bond ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vonita Rose.

(a) RESIDENCE. NO. 225 N. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 3-1919

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 001

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Strong.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tuskegee

12 MAIDEN NAME OF MOTHER Lillian Rose

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Va.

14 Informant Annie Rose. (Address) 225 N. Bond.

15 Filed OCT 23 1920 . 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1920, to Oct 22, 1920, that I last saw h[illegible] alive on Oct 21, 1920, and that death occurred, on the date stated above, at 10.20 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) measles

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? V F

(Signed) J. Edward Fisher, M. D.

10 23 1920 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Oct 24 1920
20 UNDERTAKER Chas. H. Johnson	ADDRESS

IMPORTANT: NAME should be stated EXACTLY in full. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 47478

~~D. 953~~
D. 47478
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

37

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. St.: 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Crowe

(a) RESIDENCE. No. 159 N. Mount St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 23-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Chester Crowe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Grace Jones.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hamilton Va.

14 Informant J. H. H.
(Address)

15 Filed ..., 19.. Robert P. Harrison, Registrar

OCT 23 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1920, to Oct 22, 1920, that I last saw h[er] alive on Oct. 22, 1920, and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Syphilis life
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. C. Davison, M. D.

, 19 (Address) J H H Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct. 25 1920

20 UNDERTAKER G. F. Walker ADDRESS 723 W. Lafayette

CAUSE OF DEATH must be properly classified, so that it may be tabulated according to the standard classification of diseases, and the International Classification of Causes of Death. See instructions on back of certificates.

TION is very important.

D.47479 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47479

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 835 W Saratoga ST. 18 WARD) REGISTERED NO. C...

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt. L. Harrison,

(Residence in Baltimore: No. 835 W. Saratoga St. 26 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, Don't Know, 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
26 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 640

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Thos Harrison

11-BIRTHPLACE OF FATHER (State or Country). S. C.

12-MAIDEN NAME OF MOTHER Mary J. Wales

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos Harrison

(Address) 835 W. Saratoga St

15- Robert P. Harrison,

Filed ..., 191... Registrar.

OCT 23 1920 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 20, (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) ... yrs. ... mos. 5 ds.

(Signed) W. S. Gorsuch (Coroner.) M. D.

10-23 1920 (Address) 117 W. Saratoga St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	Oct 23, 1920
20-UNDERTAKER Geo. N. Fradenburg	ADDRESS 1423 Ward St

Spec.—8-24-14—M. & T.—2000 Bks.

D.47480

HEALTH DEPARTMENT—CITY OF BALTIMORE D.47480

CERTIFICATE OF DEATH.

REGISTERED No. C 80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1600 N. Broadway ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George L. Greenwood.

(Residence in Baltimore: No. 1600 N. Broadway St. 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) married

6-DATE OF BIRTH, July 7, 1853.
(Month) (Day) (Year)

7-AGE, 65 yrs. 3 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Wm. S. Greenwood

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Celesta V. Greenwood

(Address) 1613 N. Broadway

15- Filed OCT 23 1920, 191.... Registrar.

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 22, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 20 1920, to Oct 22 1920, that I saw h im alive on Oct. 22 1920, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm J. Watson M. D.

Oct 22 1920 (Address) 2178 St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cemetery — DATE OF BURIAL, Oct 25, 1920

20-UNDERTAKER Robt J Turner & Bro — ADDRESS 1410 N Broadway

important. See instructions on back of certificate.

D47481

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D47481

15

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 4662, Kernwood Ave., ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Rogers,

(Residence in Baltimore: No. 4662, Kernwood Ave., St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
female	white	single

6-DATE OF BIRTH: October, 23, 1920 (Month) (Day) 1 (Year)

7-AGE: — yrs. — mos. — ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: none 000
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE (State or country): Md.

PARENTS

10-NAME OF FATHER: Thomas F. Rogers,

11-BIRTHPLACE OF FATHER (State or country): Penna.

12-MAIDEN NAME OF MOTHER: Marie B. Finegan,

13-BIRTHPLACE OF MOTHER (State or country): Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas F. Rodgers

(Address) 4662. Kernwood Ave

15- OCT 23 1920 Filed ..... 191 Robert P. Harrison, REGISTRAR

Burial Permit O.K.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: October, 23, 1920 (Month) (Day) 191 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1920 ....., 191....., to, Oct. 23, 1920 ....., 191.....,

that I saw her alive on Oct. 23, 1920 ....., 191.....,

and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorhage

15 Minuets
(Duration) ..... yrs ..... mos. ..... ds.

Contributory (SECONDARY) .....
(Duration) ..... yrs ..... mos. ..... ds.

(Signed) J. Royston Green M. D.

10/23/20 ....., 191 [Address] Towson, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt. Maria Cem.	Oct 25 1920
20-UNDERTAKER	**ADDRESS**
John Burns Sons	Towson

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.47482

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47482

CERTIFICATE OF DEATH.

X 28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 29 N. Bruce ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Bingham

(a) RESIDENCE. No. 29 N. Bruce ST., WARD. New York, N. Y.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colrd

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of: Henry Bingham

6 DATE OF BIRTH (month, day, and year): Nov 25, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Petersburg, Va.

PARENTS

10 NAME OF FATHER: John Gill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Emma Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Mrs. Daisy Jones 138 W. 136th St. N.Y.

15 Filed OCT 23 1920 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 21 1920

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to Oct 21, 1920, that I last saw her alive on Oct 21, 1920, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? — Date of —

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Wm. Gill M. D.

10/22 1920 (Address) 108 W Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Oct 23 1920

20 UNDERTAKER: Chas F Watson

ADDRESS 431 S Smallwood Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47483

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47483

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1032 Mc Culloh ST.; 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie E. Henderson

(Residence in Baltimore: No. 1032 Mc Culloh St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Oct 24, 1881
(Month) (Day) (Year)

7-AGE, 39 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Own

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Henry Jones

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Lucy Jones

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Goodlow

(Address) 1330 Druid Hill Ave

15-

Filed ....., 191....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 4 1920, to Oct 20 1920, that I saw h alive on Oct 20 1920, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach ?

yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 2 mos. ds.

(Signed) C. B. Hughes M. D.

Oct 22 1920 (Address) 1413 D. Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Oct 23, 1920

20-UNDERTAKER Samuel Handley

ADDRESS 578 N Bond

Robert P. Harrison,
Burial Permit Clerk.

CAUSE OF DEATH: Please write plainly, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificate.

D. 47484 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 47484

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 530 Orchard ST. 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachael Wilson

(Residence in Baltimore: No. 530 Orchard St. St.; 51 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	colored	Widow

6-DATE OF BIRTH, November, 1869
(Month) (Day) (Year)

7-AGE	If LESS than 1 day,
51 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): Dill

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Enoch Emory

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Caroline Nebsby

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Turner

(Address) 530 Orchard St.

15- Filed Oct 23, 1920, 191
Robert P. Harrison,
Registrar.
Burial Permit Clerk.

OCT 23 1920

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry. find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. 6 mos. ds.

(Signed) J. R. Heuisler M. D.
(Coroner.)
October 21, 1920 (Address) 702 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cem	Oct 25, 1920
20-UNDERTAKER Samuel Hensley	ADDRESS 578 N Bridge St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.47485 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47485

CERTIFICATE OF DEATH.

64 v

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 737 Wilmer alley ST.: 17 WARD)

REGISTERED No. C ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Munsen

(Residence in Baltimore: No. 737 Wilmer alley St.; yrs., 40 mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	widower

6-DATE OF BIRTH, unknown (Month) ....., (Day) ....., 1874 (Year)

7-AGE,	If LESS than 1 day,
46 yrs. ..... mos. ..... ds.	....hrs. or ....min.?

8-OCCUPATION: 040
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): (General)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jim Munsen

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Cathrym Lee

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. Munsen

(Address) 737 Wilmer alley

15- Robert P. Harrison,

OCT 23 1920 Filed ....., 191..... Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest~~ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~inquest~~ (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
5 minutes
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) no history
(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Oct. 21, 1920 (Address) 2507 E. Lemmon ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Oct 24, 1920
20-UNDERTAKER Samuel J. Hensley	ADDRESS

D.47486 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47486

CERTIFICATE OF DEATH.

X 137

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Bayview Hospital St.: 4 WARD) REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Bowen

(Residence in Baltimore: No. 721 W. Fayette St

St.: yrs., — mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Unknown, 1 .....
(Month) (Day) (Year)

7-AGE, 19 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Stayersdam Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Carlton Coley Statler
(Address) Bond St near Broadway

15-
OCT 23 1920 Robert P. Harrison,
Filed ....., 191.....
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 16, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
General Peritonitis
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Miscarriage
(Duration) yrs. mos. ds.

(Signed) Henry Lyon Duckett M. D.
(Coroner.)
Oct 16 1920 (Address) 1800 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death Bayview yrs. ½ mos. ds. In the State Life yrs. mos. ds.
Where was disease contracted, if not at place of death? 721 W Fayette St
Former or usual residence Stayersdam

19-PLACE OF BURIAL OR REMOVAL, St. Patricks Cem. DATE OF BURIAL, 10/23 1920

20-UNDERTAKER Chas F Ward & Son ADDRESS 1180 W Mt Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.47487

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47487

CERTIFICATE OF DEATH.

1918

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Matthews

(a) RESIDENCE. NO. Provident Hospital ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) 07

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) " "
(State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country)

14 Informant Rev. Wallace R. Epperson
(Address) Mt. Calvary Rest Home, Hamilton Twp

15 Filed OCT 23 1920 19 Robert F. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22nd 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1920, to Oct 22, 1920, that I last saw h[illegible] alive on Oct 21st 1920, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Erysipelas of Face
Idiopathic
(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arthritis Deformans
(duration) 20 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry F. Brown M. D.

10/22 1920 (Address) 1501 Presstman st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Oct 25 19
20 UNDERTAKER	ADDRESS
John A Bishop & Son	1107 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47488

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47488

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1211 Harlem Ave ST.: 16 WARD)

REGISTERED NO. 1207

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Ford

(a) RESIDENCE. NO. 1211 Harlem Ave ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 15 - 1835

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 070

(b) General natore of industry, business, or establishment in which employed (or employer) Coachman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jeremiah Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles Ford
(Address) 1211 Harlem Ave

15 Filed ..... 19 Robert P. Harrison Registrar

0CT 23 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 1920

17 I HEREBY CERTIFY, That I attended deceased from July 15 1920 to Oct 20 1920
that I last saw h.. alive on Oct 19 1920
and that death occurred, on the date stated above, at 5-30 P m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical history & Urinary examination

(Signed) Edw. F. Fitzgerald M. D.

1922 1920 (Address) 1118 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	0CT 24 1920
20 UNDERTAKER	ADDRESS
Geo. H. Holland	1631 N. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47489

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47489

CERTIFICATE OF DEATH.

137

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Penn Hospital ST.; 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Thompson

(Residence in Baltimore: No. 2231 Druid Hill Ave St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single.

6-DATE OF BIRTH. Jan. 28 (Month) (Day), 1894 (Year)

7-AGE. 26 yrs. 9 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer) 668

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm H. Thompson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Augusta Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Augusta Johnson

(Address) 2231 Hermitage Hillard

15-

Filed....., 191.....

Registrar.

OCT 23 1920

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 22 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4th 1920, to Oct 22 1920, that I saw her alive on Oct 21 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicaemia

Coma

(Duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) yrs. mos. 5 ds.

(Signed) J Bayne Cott M. D.

Oct 22 1920 (Address) 357 N. Bethel

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Oct 26, 1920

20-UNDERTAKER Jno H Holland — ADDRESS 1631 Hermitage Hillard

important. See instructions on back of certificate.

(Brockmeyer)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47490

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47490

119

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1645 N. Milton Ave ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Brockmeyer

(a) RESIDENCE. NO. 1665 N. Milton St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
White	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Richard Brockmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Barbara Ulrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant (Address) Richard Brockmeyer 1665 N. Milton St

15 Filed OCT 23 1920 19 Registrar

Robert P. Harrigan, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 14. 1920. to Oct 23. 1920.

that I last saw him alive on Oct 22. 1920.

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

(Acute nephritis - 000
(Acute obstruction of bowel

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Acute obstruction of bowel (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sym

(Signed) J. W. Nachtrieb, M. D.

, 19 (Address) Henry Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct 25 1920
20 UNDERTAKER	ADDRESS
Henry Hosen Son	804 E Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.47491 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47491

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 1403 Shields alley ST.: 14 WARD) 104

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret E. Lee

(Residence in Baltimore: No. 1403 Shields alley St.; yrs. 14 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: August 10, 1919 (Month) (Day) (Year)

7-AGE: 1 yrs. 2 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.? 000

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): Infant

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Wm. H. Lee

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Bertha Banks

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. B. Parr

(Address) 1409 Brunk St

15- Robert P. Harrison,

Filed OCT 23 1920, 191.... Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: October 22, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Status epilepticus

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Harrison M. D.
(Coroner)

Oct. 22, 1920 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Oct. 24, 1920
20-UNDERTAKER	ADDRESS
Clement Hall	1745 Penna Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47492 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47492

CERTIFICATE OF DEATH. 43

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 4007 Kathland ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine J Winters

(a) RESIDENCE. No. 4007 Kathland ave ST.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married ~~Widow~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Winters

6 DATE OF BIRTH (month, day, and year) ? ? 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Manchester Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Harry Watts (Address) 4007 Kathland ave

15 Filed . 19 Registrar

OCT 23 1920 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22, 1920

17 I HEREBY CERTIFY, That I attended deceased from July - 1, 1920, to Oct. 22, 1920, that I last saw h.e alive on Oct. 22, 1920, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left Breast.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Martin W Slack, M. D.

Oct 23 1920 (Address) 806 N Fulton ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Oct. 25 1920
20 UNDERTAKER	ADDRESS
Richard H. Cauley	2016 Eutaw

CAUSE OF DEATH to be plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47493 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47493

CERTIFICATE OF DEATH. 82

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3148 Cedar Av ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry F Quick

(a) RESIDENCE. NO. 3148 Cedar Av ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katie C Quick

6 DATE OF BIRTH (month, day, and year): Apl 1 1849

7 AGE: Years 71 | Months 6 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer Stationary 630

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City of Balto

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John W Quick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary J Disney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Katie C Quick

(Address) 3148 Cedar Ave

15 Filed . 19 Robert P. Harrison, Registrar

OCT 23 1920 [Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1915, to Oct 21, 1920, that I last saw h[illegible] alive on Oct 21, 1920, and that death occurred, on the date stated above, at 12[illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 5 yrs. [illegible] mos. [illegible] ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) O H Dukes M. D

Oct 22 1920 (Address) 928 E North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: Oct 22 1920

20 UNDERTAKER: Ebenezer Thos Lon Chestnut

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact Statement of OCCUPATION is very important. See instructions on back of certificates.

D.47494 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47494

CERTIFICATE OF DEATH.

167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Maryland Gen. Hop., St.: 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Millard Bryant

(Residence in Baltimore: No. 426 Fawcett Av. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Single

6-DATE OF BIRTH, Feb 6, 1916
(Month) (Day) (Year)

7-AGE, 4 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): child

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, George Bryant

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Effie Yingling

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) North Western Police

(Address) Baltimore, Md

15-

Filed ..... 191.....

Robert P. Harrison,
Registrar.

OCT 23 1920

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 22, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Burns of body) (Accident)
Clothing caught fire from a bon fire

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. (C.) D. Hennessy M. D.
(Coroner.)

Oct. 23, 1920 (Address) 2702 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 426 Fawcett Av

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary's Hampden — DATE OF BURIAL, Oct 25 1920

20-UNDERTAKER, Ebenezer Hall — ADDRESS, 1 Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 47495 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 47495

151 V

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child's Hospital St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eleanor Ruth Anderson

(Residence in Baltimore: No. Nursery & Child's Hospital St.; ..... yrs., 1 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August 2, 1920 (Month) (Day) (Year)

7-AGE, ... yrs. 2 mos. 19 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Not Employed
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Howard Anderson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Miriam Nelly

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed ....., 191.....

OCT 23 1920

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 21, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 21 1920, to Oct 21, 1920, that I saw her alive on Oct 21, 1920, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Malnutrition

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Feiring Lowe M. D.

Oct 21, 1920 (Address) 200 E Bath St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, ...

DATE OF BURIAL, ..., 191...

20-UNDERTAKER Commissioner Health.

ADDRESS OCT 23 1920

Per. Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary. See instructions on back of certificate.

Robert P. Harrison, JOHNS HOPKINS HOSPITAL

Spec. 6-9-19—H. P. Co. 1000 Bks.

D.47496 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47496

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Minor

(a) RESIDENCE. No. 793 George St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant New City Hospital (Address)

15 Filed OCT 23 1920, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 20 1920

17 I HEREBY CERTIFY, That I attended deceased from September 15, 1920, to October 20, 1920, that I last saw her alive on October 20, 1920, and that death occurred, on the date stated above, at 11:55 P. m.

The CAUSE OF DEATH* was as follows:

Degenerative Uterine Fibroids

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism 5 min

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Oct 20/1920

Was there an autopsy? not as yet.

What test confirmed diagnosis? Micro.

(Signed) F. A. Holden, M. D.

10/20/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Oct 24 1920
20 UNDERTAKER	ADDRESS
Daniel Easton	Penna ave

Spec.—8-24-14—M. & T.—2000 Bks.

(Tartar)

D.47497

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47497

CERTIFICATE OF DEATH.

REGISTERED No. C 92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 Bond ann ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Tartar

(Residence in Baltimore: No. 604 Bond ann St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	S

6-DATE OF BIRTH, July 25 (Month) (Day) 1905 (Year)

7-AGE, 15 yrs. 2 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph Tartar

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Magdalina Bond

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos Tartar

(Address) 604 Bond ann

15-

Filed ....., 191.....

Registrar.

Robert P. Harrison,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 20 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 191.., to Oct 19 191.., that I saw h- alive on Oct 19 191.., and that death occurred, on the date stated above, at ..m.

The CAUSE OF DEATH* was as follows:

..... Pneumonia .....

..... (Duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..yrs. ..mos. ..ds.

(Signed) ..... M. D.

Oct 21, 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Farmer or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holetown	Oct 24, 191..
20-UNDERTAKER Daniel Easbin	ADDRESS 916 Penna ave

Property classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

20.47498 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.47498

175-001

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin St Hospital St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Lowe

(Residence in Baltimore: No. 507 N Longwood St

St.: yrs. 2 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	white	single

6-DATE OF BIRTH, July (Month) 17th (Day), 1915 (Year)

7-AGE, 5 yrs. 2 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Robert E Lowe

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER Florence Courtney

13-BIRTHPLACE OF MOTHER (State or Country). Balto Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Robert E Lowe

(Address) 507 N. Longwood St

15-

Filed....., 191.....

Robert P. Harrison,
OCT 26 1920
Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture L. Skull
Auto accident

(Duration)..... yrs..... mos. 1/4 ds.

CONTRIBUTORY. (Secondary) Oedema Kidneys

(Duration)..... yrs..... mos. 8 ds.

(Signed) James M Fenton M. D.
(Coroner.)

Oct 26 1920 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos. 1/4 ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Edmondson Ave Calvert Rd

Former or usual residence 507 N Longwood St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Lorraine Cem	Oct 25, 1920
20-UNDERTAKER Joseph B. Cook	ADDRESS 1003 N Balto St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47499

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47499

CERTIFICATE OF DEATH.

X 104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 352 St Helena ave ST.: 26 WARD)

2-FULL NAME Frederick Hugo Kipper Jr.

(a) RESIDENCE. No. 352 St Helena ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 24-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home. 000

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newport News, Va.

PARENTS

10 NAME OF FATHER Frederick Hugo Kipper

11 BIRTHPLACE OF FATHER (city or town) Fractus Mouse (State or country) Virginia

12 MAIDEN NAME OF MOTHER Edna May Darlington

13 BIRTHPLACE OF MOTHER (city or town) New Port News (State or country) Virginia

14 Informant Father (Address) 352 St Helena ave.

15 Filed OCT 23 1920 19.... Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1920, to Oct 23, 1920, that I last saw h[illegible] alive on Oct. 23, 1920, and that death occurred, on the date stated above, at 8-30 A. m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

(duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A.W. Reier, M. D.

10/23 1920 (Address) St Helena, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Port News, Va	10/23 1920
20 UNDERTAKER J. A. Joran	ADDRESS 3000 E Balto.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Jubeliter

20-47500

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.47500

CERTIFICATE OF DEATH.

X 41

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Osias Jubeliter

(a) RESIDENCE. No. 421 - 9th Ave Mc Keesport Pa WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Austria
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Hospital Record
(Address) J. H. H.

15 Filed ..... 19 .....

OCT 23 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22nd 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 3rd 1920 to Oct 22nd 1920, that I last saw him alive on Oct 22nd 1920, and that death occurred, on the date stated above, at 8 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 10/21/20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm F. Faehnle Jr. M. D.

, 19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
McKeesport Pa	10/23 1920
20 UNDERTAKER Jack Lewis	ADDRESS 1911 E Balt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

47501 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 47501

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Camp Holabird ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick W Jackson

(Residence in Baltimore: No. Camp Holabird St.: 1 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, April (Month) ..... (Day) ....., 1873 (Year)

7-AGE, 47 yrs. 6 mos. ..... ds. — If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Soldier U.S.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), New York City N.Y.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Master Sgt Martin Sutter

(Address) Camp Holabird Md

15- OCT 24 1920 ROBERT B KRAUTER

Filed....., 191... Chief Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 22 1920, to Oct 22 1920, that I saw him alive on Oct 22 1920, and that death occurred, on the date stated above, at 1.20 a. m.

The CAUSE OF DEATH* was as follows:

Heart Block

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) E.R. Grist, Capt. Med Corps M. D.

....., 191... (Address) Camp Holabird, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. — In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence San Diego Cal

19-PLACE OF BURIAL OR REMOVAL, San Diego Cal. — DATE OF BURIAL, 10/24, 1920

20-UNDERTAKER Jack Levis — ADDRESS 1411 E. Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

D47502 HEALTH DEPARTMENT—CITY OF BALTIMORE D47502

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 addison alley St. 19 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Henson

(Residence in Baltimore: No. 526 addison alley St. 1/10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, colr

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, aug 11, 1875.
(Month) (Day) (Year)

7-AGE, 45 yrs. 2 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

040

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jas Henson

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER Caroline Hollins

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pearl Henson

(Address) 526 Addison Alley

15- OCT 24 1920 ROBERT F. KRAUTER Registrar.
Filed....., 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 21, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from oct 13 1920, to oct 20 1920, that I saw h m alive on oct 20 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

Toxaemia or Uraemia

Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) yrs. mos. ds.

(Signed) J. B. Hall M. D.

10-24-1920 (Address) Hatchet st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Oct. 24th 1920

20-UNDERTAKER A. Jones ADDRESS 207 S. Stricker st 207 S. Stricker st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047503

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047503

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 637 Mosher ST. 14 WARD)

2-FULL NAME Singleton R. Hughes

(a) RESIDENCE. NO. 637 Mosher ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Hughes

6 DATE OF BIRTH (month, day, and year) Jan 20-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	60	9 mo.	1 day	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister 018

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co (State or country) Md.

PARENTS

10 NAME OF FATHER Singleton Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Warfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rev. W. A. Teague (Address) 627 Meade St.

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1920, to Oct 21, 1920, that I last saw h[illegible] alive on Oct 21, 1920, and that death occurred, on the date stated above, at 1.40 P m.

The CAUSE OF DEATH* was as follows:

Rheumatic Fever.

...(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Endocarditis Acute

...(duration) ... yrs. ... mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical history

(Signed) Edw. J. Fitzgerald M. D.

10/22/20 (Address) 1118 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int. Auburn Cem.	Oct 24 1920
20 UNDERTAKER Geo. W. Hollands	ADDRESS 1631 Vermont Ave

OCT 23 1920 ROBERT P. BLATTNER
Burial Permit Clerk

information should be carefully supplied. Exact statement of OCCUPATION should be given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

0475-04 0475-04 38 ✓ 0475-04

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3102 Barley ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Harrison

(a) RESIDENCE. No. 3102 Barley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth Harrison

6 DATE OF BIRTH (month, day, and year) Aug 19 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 070

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer Hospital

(c) Name of employer Bethlehem Steel Co Baltimore

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Lewis Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella Carmichael

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Ella Harrison 3102 Barley St

15 Filed OCT 24 1920 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1920

17 I HEREBY CERTIFY, That I attended deceased from June 10 1920 to Oct 19 1920, that I last saw him alive on Oct 19 1920, and that death occurred, on the date stated above, at 5-a. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dying indefinite

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ex Bacteriology

(Signed) J. Garland Schmitt M. D.

(Address) 1534 E. H. Ave 10/22 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. | DATE OF BURIAL 10/24/20

20 UNDERTAKER Mr. J G Locks | ADDRESS 1302 Jefferson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ROBERT E [illegible] Registrar

Burial Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047505 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047505

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Williams

(a) RESIDENCE. No. 1126 E. Lexington St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Atlanta Georgia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M.T.H.

15 Filed OCT 24 1920 ROBERT B. LEAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1920, to Oct. 22, 1920, that I last saw h im alive on Oct. 21, 1920, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. J. Rigney, M. D.

10-22-20. 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Oct 25 1920
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Av

INSTRUCTIONS—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Nelson M. Williams

0447506 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

0447506

CERTIFICATE OF DEATH.

48

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1429 Myrtle ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME N. M. Williams

(Residence in Baltimore: No. 1429 Argyle St. 22 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Oct 27, 1893 (Month) (Day) (Year)

7-AGE, 27 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER, C. E. Williams

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Emma Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. E. Williams

(Address) 1429 Argyle St.

15-

Filed ....., 191.....

Registrar.

OCT 24 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 22, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1- 1920, to Oct 22 1920, that I saw h[illegible] alive on Oct 20 1920, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

1 Epithelioma Rectum

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Chronic

(Duration) yrs. 17 mos. ds.

(Signed) H. J. Coleman M. D.

Oct 22 1920 (Address) 2039 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Oct 25, 1920

20-UNDERTAKER Geo. Robert & Elliott

ADDRESS 1725 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D47507

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47507

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 N Bruce ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Gardner

(Residence in Baltimore: No. 503 N Bruce St.; 9 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	single

6-DATE OF BIRTH, Dec. (Month) 13 (Day), 1907 (Year)

7-AGE, 12 yrs. 10 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School boy
(b) General nature of industry, business, or establishment in which employed (or employer): Not able to attend for past year

9-BIRTHPLACE, (State or Country), Jessup Md

PARENTS.

10-NAME OF FATHER, James E. Gardner

11-BIRTHPLACE OF FATHER (State or Country), Ellicott City Md

12-MAIDEN NAME OF MOTHER Rose Cooks

13-BIRTHPLACE OF MOTHER (State or Country), Jessup Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Gardner

(Address) 503 N. Bruce St.

15-

OCT 24 1920 ROBERT B KRAUTER

Filed....., 191.... BURIAL PERMIT Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 21 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 11- 1920, to Oct. 20- 1920, that I saw him alive on Oct. 20- 1920, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Chronic articular rheumatism

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac hypertrophy & Valvular lesion (Duration) about 3 yrs. mos. ds.

(Signed) Chas. L. McCarthy M. D.

Oct. 22, 1920 (Address) 906 N. Monroe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Forest Lawn Cem. Co.	Oct 24, 1920
20-UNDERTAKER	**ADDRESS**
Jam. H. Chase & Son	406 Monroe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D47508 HEALTH DEPARTMENT—CITY OF BALTIMORE D47508

CERTIFICATE OF DEATH.

79

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1046 Druid Hill Ave ST.: 18 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ella Butler

(Residence in Baltimore: No. 1106 2 St Washington DC 1046 Druid Hill Ave St. 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... September ..... 1 ..... (Month) (Day) (Year)

7-AGE, 37 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... H W
(b) General nature of industry, business, or establishment in which employed (or employer) ..... at home

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Wm Fortune

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel J Butler

(Address) 1106 2 St Washington DC

15- Filed OCT 24 1920, 191.... ROBERT E KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct ..... 23, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquest ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... Inquest ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

Chronic

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Chronic (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jerome M Fenton M. D. (Coroner.)

Oct 23, 1920 (Address) 701 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Washington D C	Oct 24th 1920
20-UNDERTAKER	**ADDRESS**
Jam H Chase Son	1400 Monroe

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47509

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47509

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 42 S. Carolina ST.; B WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raizel Buroch

(a) RESIDENCE. NO. 42 So. Carolina ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Label Buroch

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Yozel Novack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Raizel Novack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Daughter

(Address) 42 So Carolina St.

15 Filed OCT 24 1920 ROBERT S. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Octo 22nd 1920

17 I HEREBY CERTIFY, That I attended deceased from Octo 4th, 1920, to Octo 22nd, 1920, that I last saw her alive on Octo 22nd, 1920, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 1? mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samil Snyder, M. D.

, 19 (Address) 38 So. Carolina St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	10/24 1920
20 UNDERTAKER	ADDRESS
Jack Levin	1411 E Balt

INSTRUCTIONS: This certificate should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Kunin

1047570 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047510

CERTIFICATE OF DEATH. 167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Josh Hospital WARD) (If death occurred in hospital or institution give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Isaac Kunin

(Residence in Baltimore: No. 1921 E. Pratt St. St. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Baby

6-DATE OF BIRTH, June 15, 1916
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
4 yrs. 4 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child 901
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Abraham Kunin

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Mollie Hall

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... L. Levis

(Address)..... 1411 E. Biddle

15- OCT 24 1920 ROBERT E. KRAUTER

Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 23, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns while playing with matches (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. Kent Insley M. D.
(Coroner.)

10-27-1920 (Address) 711 E. Lex.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Workmen Circle, Mt Carmel	....., 19...
20-UNDERTAKER	ADDRESS
Sack-Levis	1411 E Biddle

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D47511 HEALTH DEPARTMENT—CITY OF BALTIMORE D47511

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1032 Bare ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Cadden

(a) RESIDENCE. No. 1032 W. Barre ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Cadden

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Daniel Cassidy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant John Cadden

(Address) 1032 W. Barre St

15 Filed OCT 24 1920 ROBERT L. BRAUER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1920.

17 I HEREBY CERTIFY, That I attended deceased from Sept 7 1920. to Oct 21 1920. that I last saw h alive on Oct 21 1920. and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Jas L. Hooper, M. D.

Oct. 1920 (Address) 346 E. 25th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudan Park.	Oct 25th 1920
20 UNDERTAKER	ADDRESS
John A. Moran	3000 E. Balto.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D47512

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47512

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 N. Hare ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Smith

(a) RESIDENCE. NO. 132 N. Hare ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Smith

6 DATE OF BIRTH (month, day, and year) Nov. 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Amend

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorthman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Henry Smith

(Address) 132 N. Hare St.

15 Filed OCT 24 1920 ROBERT E. KRAUTER Registrar

Burial Permit Clerk

Hearn - Luzerne & Balto

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1920, to Oct 21, 1920, that I last saw her alive on Oct 21, 1920, and that death occurred, on the date stated above, at 5.30 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Hearn M. D.

Oct 19 20 (Address) 2600 Eutaw, Ct.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer,	Oct 25th 192
20 UNDERTAKER	ADDRESS
John A. Moran	3000 E. Balto,

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

47513 HEALTH DEPARTMENT—CITY OF BALTIMORE 2047513

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 S. 4th St.; 26 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Forest Gray

(Residence in Baltimore: No. 704 S. 4th St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	wh.	Single

6-DATE OF BIRTH, Dec. (Month) 1 (Day), 1919 (Year)

7-AGE, yrs. 10 mos. 23 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Balto City, Md.

PARENTS.

10-NAME OF FATHER, Arthur Gray

11-BIRTHPLACE OF FATHER (State or Country) North Carolina

12-MAIDEN NAME OF MOTHER Inia Pardue

13-BIRTHPLACE OF MOTHER (State or Country) North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Gray

(Address) 704 S. 4th St.

15- OCT 24 1920 ROBERT N. KRAUTER

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 15 1920, to Oct. 23 1920, that I saw him alive on Oct. 23 1920, and that death occurred, on the date stated above, at 12:25 P.M.

The CAUSE OF DEATH* was as follows:

Meningitis - Cerebro-Spinal

(Duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Laurence B. Athey M. D.

10/23, 1920. (Address) 2504 St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Leitsdia North Carolina Pleasant Grove Cem.	Oct 26, 1920
20-UNDERTAKER Lilly and Zirkin	ADDRESS 403 S. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Gauges

HEALTH DEPARTMENT—CITY OF BALTIMORE

647514 647514

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 754 N Franklin St.; 17 WARD) REGISTERED NO. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amanda Gauges

(Residence in Baltimore: No. 754 N Franklin St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (*Write* the word.)
Female	Colored	Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1842 (Year)

7-AGE, 78 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Fauquier Co Va

PARENTS.

10-NAME OF FATHER, Chas Dalen

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Jane Proctor

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George C. Jackson

(Address) 564 Hilton St

15- Filed OCT 24 1920, 191.... ROBERT P. BRAUTER Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 21 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 3 1920, to Oct 21 1920, that I saw her alive on Oct 20 1920, and that death occurred, on the date stated above, at 1130 a m.

The CAUSE OF DEATH* was as follows:

Heart disease

Prostration

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

3 mos. (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. H. Carey M. D.

Oct 24, 1920. (Address) 1500 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Oct 24th, 191...

20-UNDERTAKER Samuel P. Hunter — ADDRESS 578 W Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D47515 HEALTH DEPARTMENT—CITY OF BALTIMORE D47515

CERTIFICATE OF DEATH. X 169

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Foot of Black St. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick J Maloney

(Residence in Baltimore: No. Sparrows Pt.

St.: yrs. (3 mos.) ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, March 1, 1886
(Month) (Day) (Year)

7-AGE, 36 yrs. 7 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): Bet. Bethlehem Steel Co Sparrows Pt Md

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, James Maloney

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Langan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Jno McGovern

(Address) 622 North Ave B, Bethlehem Pa

15- OCT 24 1920 ROBERT E LEAUTER Registrar.
Filed....., 191.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 22, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Dr. Oursler M. D.
(Coroner.)
10/24, 1920 (Address) 1600 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Bethlehem Pa

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Bethlehem Pa	Oct 24, 1920

20-UNDERTAKER	ADDRESS
John F Danny	715 Light St

0475516 HEALTH DEPARTMENT--CITY OF BALTIMORE D. 47516

CERTIFICATE OF DEATH 42

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 1528 Park Ave St. 14 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence A. Blackiston

(Residence in Baltimore: No. 1528 Park Ave. St. 10 yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY: PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: F

4-COLOR OR RACE: W.

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married.

6-DATE OF BIRTH: January 10, 1864 (Month) (Day) (Year)

7-AGE: 56 yrs. 7 mos. 7 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): D37

9-BIRTHPLACE (State or country): Maryland.

PARENTS

10-NAME OF FATHER: John Keyser

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Ella Smith

13-BIRTHPLACE OF MOTHER (State or country): Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Douglas C. Blackiston

(Address) 607 Melville ave

15 OCT 24 1920 ROBERT P. EGLOFFE Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct 23, 1920 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Dec 1, 1917, to Oct 23 1920 that I saw h e alive on Oct 22, 1920 and that death occurred, on the date stated above, at 8 A. m

The CAUSE OF DEATH* was as follows:

Carcinoma Uteris
Ascites 3 yrs ago-recurrence
(Duration) 3 yrs. mos. ds.

Contributory (SECONDARY) Embolus to Lung 10 mins
(Duration) yrs. mos. ds.

(Signed) Stephen Gatch M. D.
Oct 23 1920 (Address) 704 N Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Druid Hill Cemetery — DATE OF BURIAL: Oct 25 1920

20-UNDERTAKER: John Ortel Chatfield — ADDRESS: Fayette St

D47517 HEALTH DEPARTMENT—CITY OF BALTIMORE D47517

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Emerson Hosp ST.: 25 WARD) REGISTERED No. C. 20

2-FULL NAME Klemens Zebron

(Residence in Baltimore: No. Curtis Bay

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St: 14 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1876 (Year)

7-AGE, 44 yrs. 0 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Margaret Seward

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanislaw Zebron

(Address) 8 Church St

15- OCT 24 1920 ROBERT J KRAUTER

Filed....., 191.... Burial Permit Issued Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 22 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured ... (Caught [illegible] Cable in motor) ... (Duration) about 2 hrs. ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) H. F. Daly M. D. (Coroner.)

Oct 22, 1920 (Address) 9 39 Bruce

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. 2½ mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence 8 Church St Curtis Bay

19-PLACE OF BURIAL OR REMOVAL Holy Cross Cem DATE OF BURIAL, Oct 25 1920

20-UNDERTAKER H. Haegarty ADDRESS 818 Curtis

Missing

#D 47518

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047519

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047519

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2132 Cambridge ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Teresa Chandley

(a) RESIDENCE. No. 2132 Cambridge ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H Chandler

6 DATE OF BIRTH (month, day, and year) Feb 14 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 400

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) State or country) Va

10 NAME OF FATHER David Rhea

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER M "

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Ella L Farmer

(Address) 2132 Cambridge St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1920

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1920, to Oct. 22, 1920, that I last saw h.. alive on Oct. 22, 1920, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Catarrh

(duration) ... yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Muscular Debility

(duration) 4 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 2113 Ramsay St City

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) John H. Rehberger M. D.

, 19 (Address) 1709 Aliceanna St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Oct 24 1920

20 UNDERTAKER Wm Cook

ADDRESS 1+39 W

Spec.—6-9-19—H. P. Co.—1000 Blks.

1047520

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047520

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital. ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Edward Smith

(a) RESIDENCE. No. Unknown ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rigger 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk, Va.
(State or country)

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) Norfolk, Va.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Norfolk, Va.
(State or country)

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed ....., 19.....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 21, 1920

17 I HEREBY CERTIFY, That I attended deceased from October 14, 1920, to October 21, 1920, that I last saw him alive on October 21, 1920, and that death occurred, on the date stated above, at 12:40 P. m.

The CAUSE OF DEATH* was as follows:

Linitis plastica

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Ulcerative colitis (non-specific) (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy findings

(Signed) H. Hartman, M. D.

10-21-20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 25 1920
20 UNDERTAKER	ADDRESS
William Cook	502 E. North Ave

OCT 24 1920
Burial Permit Clerk

Spec.—8-24-14—M. & T.—2000 Blks.

047521 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 047521

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 N. Gilmore ST.: 15 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ann Hirsch

(Residence in Baltimore: No. 1315 N. Gilmore St.; 64 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Nov. 5th, 1840 (Month) (Day) (Year)

7-AGE. 79 yrs. 11 mos. 17 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE. (State or Country) Baltimore, Md

PARENTS.

10-NAME OF FATHER. William Foster

11-BIRTHPLACE OF FATHER (State or Country). Maine

12-MAIDEN NAME OF MOTHER Grace MacCracken

13-BIRTHPLACE OF MOTHER (State or Country). Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. August Hirsch

(Address) 1315 N. Gilmore St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 22, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1st 1919, to Oct 22d 1920, that I saw her alive on Oct 22d 1920, and that death occurred, on the date stated above, at 11.25 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Millitus

..... (Duration) yrs. 10 mos. 22 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edw. A. Pennewell M. D.

Oct 22d, 1920 (Address) 538 N. Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Oct 25, 191.
20-UNDERTAKER William Cook	ADDRESS 502 E. Nor... Ave

D47522

HEALTH DEPARTMENT—CITY OF BALTIMORE

Males
156 Burning, Fayette
D47522

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 11 East Lanvale St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian M. Waggoner

(Residence in Baltimore: No. 11 East Lanvale St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, June (Month) 21 (Day), 1879 (Year)

7-AGE, 41 yrs. 4 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... At Home

037

9-BIRTHPLACE, (State or Country), A. A. Co. Md

PARENTS.

10-NAME OF FATHER Arthur Mueller

11-BIRTHPLACE OF FATHER (State or Country) A. A. Co. Md

12-MAIDEN NAME OF MOTHER Theresa Sweitum

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theodore R. Waggoner

(Address) 11 East Lanvale

15-

Filed OCT 24 1920 191... ROBERT B KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide Hung Self.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Broken Constitution

(Duration) ....yrs. ....mos. ....ds.

(Signed) R. Coulson Bladel M. D. (Coroner.)

10/24/20, 191... (Address) 1436 Biway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Millersville A.A.Co. Md. DATE OF BURIAL, Oct 26 1920

20-UNDERTAKER William Cook ADDRESS 502 E North Ave

D47523 HEALTH DEPARTMENT—CITY OF BALTIMORE D47523

CERTIFICATE OF DEATH.

175-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Bon Secours Hospital ST.: 70 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter, T. Geary Jr.

(Residence in Baltimore: No. 2001 W Saratoga St.; yrs., 2½ mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word)
Male	white	Single

6-DATE OF BIRTH, May (Month) 18 (Day), 1918 (Year)

7-AGE, 2 yrs. 5 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, Walter T. Geary

11-BIRTHPLACE OF FATHER (State or Country), Balto city

12-MAIDEN NAME OF MOTHER alice L. Young

13-BIRTHPLACE OF MOTHER (State or Country), Balto city

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter T. Geary

(Address) 2001 W Saratoga St

15- OCT 24 1920 ROBERT B KRAUTER Burial Permit Clerk

Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 21 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
Auto accident

(Duration) ....yrs. ....mos. 8 hrs.

CONTRIBUTORY (Secondary) Hemorrhage of brain (Duration) ....yrs. ....mos. 8 hrs.

(Signed) James Mullen M. D.
(Coroner.)

Oct 22 1920 (Address) 1 W. E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 8 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Front & 2001 W Saratoga St

Former or usual residence 2101 W Saratoga St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem	10/25/20
20-UNDERTAKER	**ADDRESS**
A C Fleming & Son	517 N Schroeder

Spec.—6-9-19—H. P. Co.—1000 Bks.

Price

0475524 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓0475524

45

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Price

(a) RESIDENCE. No. 2109 Oliver st. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of: widow

6 DATE OF BIRTH (month, day, and year) April 28 - 1841

7 AGE: Years 79 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Off

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Talbot Co (State or country) Md

PARENTS

10 NAME OF FATHER Henry

11 BIRTHPLACE OF FATHER (city or town) Talbot Co (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Shea

13 BIRTHPLACE OF MOTHER (city or town) Balto Co (State or country)

14 Informant Harry Price
(Address) No. 625 N. Casey

15 Filed OCT 24 1920 19 ROBERT B. QUANTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 24 1920

17 I HEREBY CERTIFY, That I attended deceased from September 26, 1920, to October 24, 1920, that I last saw him alive on October 24, 1920, and that death occurred, on the date stated above, at 6-40 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic intest nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical & physical

(Signed) N. J. Lombardi, M. D.

, 19 (Address) Franklin Sq. Hospl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 10-26-1920

20 UNDERTAKER: H. C. Hammersla

ADDRESS 617 N Schroeder St

Spec.—8-24-14—M. & T.—2000 Bks.

947525 HEALTH DEPARTMENT—CITY OF BALTIMORE 947525

151

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 732 Bartlett av ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Def of Chas. & Emma Robinson

(Residence in Baltimore: No. 732 Bartlett av St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Oct 23, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or 10 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

10-NAME OF FATHER Chas. E Robinson

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Emma Durcho.

13-BIRTHPLACE OF MOTHER (State or Country), N. Y.

14-THE ~~ABOVE~~ IS TRUE TO THE ~~BEST~~ OF MY KNOWLEDGE.

(Informant) Mrs. Emma Robinson

(Address) 732 Bartlett av

Filed OCT 24 1920, 191... ROBERT B. ERAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 23, 1920 (Month) (Day) (Year)

17) I HEREBY CERTIFY, That I attended deceased from Oct 22 1920, to Oct 23 1920, that I saw h.. alive on Oct 23 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Premature Birth.
6 Mo.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Premature Birth

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas. E Robinson M. D.

Oct 23, 1920 (Address) 718 N Paca St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, John Hopkins Med School | DATE OF BURIAL, ..., 191...

20-UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

047526

X64 ✓

STATE OF MARYLAND
CERTIFICATE OF DEATH

D:47526

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

~~County~~ Baltimore City

Village or City ..... (No. Roland & Lake Aves. St. 27 Ward)

2 FULL NAME Walter L. Clack

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH: October 9, 1874 (Month) (Day) (Year)

7 AGE: 46 yrs. 0 mos. 15 ds. If LESS than 1 day, ... hrs. OR ..... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Lumber Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9 BIRTHPLACE (State or country): Boydton, Virginia

PARENTS

10 NAME OF FATHER: Robert H. Clack

11 BIRTHPLACE OF FATHER (State or country): Virginia

12 MAIDEN NAME OF MOTHER: ---------- Thrower

13 BIRTHPLACE OF MOTHER (State or country): Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. H. A. Taylor

(Address) Richmond, Virginia

15 Filed OCT 25 1920, 191 ROBERT B KRAUTER (Registrar)

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October 24 (Month) (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1920 to Oct 24, 1920

that I last saw h— alive on Oct 24, 1920

and that death occurred on the date stated above, at 10 A M

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 1 yrs. 0 mos. 6 ds.

Contributory / Secondary: Central Hemmorhage

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Julius Freedman, M. D.

(Address) 1013 St Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death ..... yrs. 2 mos. ..... ds. In the State ..... yrs. 3 mos.

Where was disease contracted, if not at place of death?

Former or usual residence: Richmond, Va

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Boydton, Virginia	10/ ....., 191

20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Via Penn. R.R. - H. A. Taylor Escat.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47527

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47527

CERTIFICATE OF DEATH.

20

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Davis.

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter--Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co., Maryland

PARENTS

10 NAME OF FATHER George Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed OCT 25 1920 ROBERT B. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 23, 1920

17 I HEREBY CERTIFY, That I attended deceased from October 11, 1920 to October 23, 1920 that I last saw him alive on October 22, 1920 and that death occurred, on the date stated above, at 2:00 A.m.

The CAUSE OF DEATH* was as follows:

Septic ulcer right leg (not traumatic)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) F. A. Holden, M. D.

10/23/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Oct 25 1920
20 UNDERTAKER David Garton	ADDRESS 916 Pa ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047528

HEALTH DEPARTMENT—CITY OF BALTIMORE

047528

82

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 157 W. Lanvale ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Berkeley Paine

(a) RESIDENCE. NO. 157 N. Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~ or ~~Divorced~~ (write the word)
Female	white	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John. L. Paine

6 DATE OF BIRTH (month, day, and year) Jan 31st 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady 137

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover Co Va

PARENTS

10 NAME OF FATHER Richard F. Berkeley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Betty Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) John L Paine 157 W. Lanvale.

15 Filed OCT 25 1920 19 ROBERT R KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23d 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 5th, 1920, to Oct. 23d, 1920, that I last saw h.. alive on Oct. 22nd, 1920, and that death occurred, on the date stated above, at 2. a m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis

(Death 24 hours fm second attack)

(duration) ✓ yrs. 2 mos. ✓ ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) E McV Hanes M.D. M. D.

10.23. 1920 (Address) 1515 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	Oct 25th 1920
20 UNDERTAKER	ADDRESS
Henry W. Jenkins Sons Co.	McCreedy + Orchard

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047529

HEALTH DEPARTMENT—CITY OF BALTIMORE

047529

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2006 Eutaw Place ST. 14 WARD)

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ross N. Bowers,

(a) RESIDENCE. NO. 2006 Eutaw Place ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 30. 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real Estate Agent

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm. Bowers,

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Ann Noble,

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Frank K Bowers
(Address): 2006 Eutaw Place

15 Filed OCT 25 1920, 19 ROBERT B. ERAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1920

17 I HEREBY CERTIFY, That I attended deceased from July, 1920, to Oct 24, 1920, that I last saw him alive on Oct 23, 1920, and that death occurred, on the date stated above, at 1 9 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Frederick Leitz, M. D.

10/24 1920 (Address) 2040 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem.

DATE OF BURIAL: Oct. 26. 1920

20 UNDERTAKER: Geo W Little

ADDRESS: 531 N. Fremont.

PRINT PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1947530

HEALTH DEPARTMENT—CITY OF BALTIMORE

1947530

CERTIFICATE OF DEATH.

X 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1927 E. Biddle ST.; 8 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Redd Jr

(Residence in Baltimore: No. 1927 E Biddle St.: yrs., 2 mos. 15 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Apr 11, 1920 (Month) (Day) (Year)

7-AGE, yrs. 6 mos. 12 da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Not any
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, John Redd

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Lillie Stokes

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie Redd

(Address) 1927 E. Biddle St

15- OCT 25 1920 ROBERT B KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 23, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 20 1920, to Oct 23 1920, that I saw him alive on Oct 23 1920, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Gastro intestinal catarrh

(Duration) yrs. mos. 7 da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) J. E. Thomas M. D.

Oct 24 1920. (Address) 822 N. Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence Virginia

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Oct 25, 1920

20-UNDERTAKER Mrs Robert F Elliott Parkland Md ADDRESS 1725

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD—INK

Spec. 6-9-19—H. P. Co.—1000 Bks.

0475 31

HEALTH DEPARTMENT—CITY OF BALTIMORE

0475 31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 Pennington Ave ST.: 25 WARD) 40

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl A. Morck.

(a) RESIDENCE. No. 912 Pennington Ave ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Morck.

6 DATE OF BIRTH (month, day, and year) Feby 25th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 01

(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter.

(c) Name of employer U.S Coast Guard.

9 BIRTHPLACE (city or town) (State or country) Haland, Norway

PARENTS

10 NAME OF FATHER Christopher Morck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway,

14 Informant John E. Morck Jr.
(Address) 111 Stanwood Ave Highland

15 Filed ..... 19 ..... Registrar

BURIAL Burial Permit OCT 25 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1920

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1920, to Oct 22, 1920, that I last saw h alive on Oct 21, 1920, and that death occurred, on the date stated above, at 10 20 9. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know.

Did an operation precede death? yes Date of Feb. 1920

Was there an autopsy? No

What test confirmed diagnosis? Operation.

(Signed) William A Cardy, M. D.

, 19 (Address) 816 Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. Co.	Oct 26 1920
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Light St.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec. 6-9-19 H. P. Co.—1000 Blks.

047532 HEALTH DEPARTMENT—CITY OF BALTIMORE 79 047532

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1749 Jackson ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie J. Carney.

(a) RESIDENCE. No. 1749 Jackson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Carney.

6 DATE OF BIRTH (month, day, and year) Feb 28 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Anne Layburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Thomas F. Carney

(Address) 1749 Jackson St.

15 Filed OCT 25 1920 ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-22-1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1st, 19.., to Oct. 22nd, 1920, that I last saw her alive on Oct. 21st, 1920, and that death occurred, on the date stated above, at 5-20 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart - Lumbago

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. E. Hayward, M. D.

Oct 23, 1920 (Address) 1235 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peter's Cem.	Oct. 25 1920
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1422 Light St.

MUST BE WRITTEN WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

28 D47533

STATE OF MARYLAND
CERTIFICATE OF DEATH

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
~~County~~ D47533

Registration Dist. No. 16

Village or City Baltimore (No. 1117, N. Carey St.; or Ward)

[If death occurred in a hospital or institution give its NAME instead of street and number.]

2 FULL NAME Teckla Henson Allen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	Colored	Married

6 DATE OF BIRTH: November 11th (Month) (Day), 1884 (Year)

7 AGE: 35 yrs. 11 mos. 10 ds. If LESS than 1 day, ✓ hrs. OR ✓ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): ✓

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Louis Henson.

11 BIRTHPLACE OF FATHER (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Sarah A Ennis.

13 BIRTHPLACE OF MOTHER (State or country): Balto Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Willard V. Allen.

(Address) 1117 N. Carey St.

15 Filed ROBERT P. LAMAN, REGISTRAR, BALTIMORE CITY, OCT 25 1920, Oct 25, 191

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October 21st (Month) (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June, 1920, to Oct 21st, 1920, that I last saw her alive on Oct 21st, 1920, and that death occurred on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH * was as follows:

Pulmonary tuberculosis

(Duration) ✓ yrs. 9 mos. ✓

Contributory / Secondary: Ex Lawsteri - secondary

(Duration) yrs. 3 mos.

(Signed) Edward V. Beetler

Oct 23, 1920 (Address) Health of Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death 35 yrs. 11 mos. 10 ds. In the State 35 yrs. 11 mos. ✓

Where was disease contracted, if not at place of death? ✓

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn — DATE OF BURIAL: Oct 25, 1920

20 UNDERTAKER: John H. Toadvine — ADDRESS: Wilkes

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47534

CERTIFICATE OF DEATH.

64 D 47534

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital. ST.: 77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Cole

(a) RESIDENCE. No. 121 York St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Eastern Shore, Maryland

PARENTS

10 NAME OF FATHER: Henry Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Eastern Shore, Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Eastern Shore, Maryland

14 Informant: Hospital Records, (Address) New City Hospital.

15 Filed OCT 25 1920 19 ROBERT A. SLAUTER Registrar

Special Form 4 Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 22, 1920

17

I HEREBY CERTIFY, That I attended deceased from September 23, 1920, to October 22, 1920.

that I last saw her alive on October 22, 1920.

and that death occurred, on the date stated above, at 6:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse Nephritis
Arterio-Sclerosis & Hypertension

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? 121 York St.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) W. B. Fetman M. D.

10/23/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Oct 26 1920
20 UNDERTAKER	ADDRESS 142
John H. Toadvine	W Hill St

Spec.—6-9-19—H. P. Co.—1000 Bks.

047535 HEALTH DEPARTMENT—CITY OF BALTIMORE 047535

CERTIFICATE OF DEATH. X 28

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3448 Cedar Ave (Ward) 13

2-FULL NAME Margaret E Adelsperger

(a) RESIDENCE. No. Laurel Md St., Ward. Laurel Md:
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Adelsperger

6 DATE OF BIRTH (month, day, and year): March 10 1864

7 AGE: Years 62; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Del

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Harvey Merson
(Address) 3448 Cedar Ave

15 Filed OCT 25 1920 ROBERT E LEE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 23 1926

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 1926 to Oct 23 1926 that I last saw h[er] alive on Aug 23 1926 and that death occurred, on the date stated above, at 12.30 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Pulmonary tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of none

Was there an autopsy? no

What test confirmed diagnosis? Characteristic Symptoms

(Signed) Amon F Kelly, M. D.

Oct 27 1926 (Address) 3705 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Md — DATE OF BURIAL: Oct 26 1926

20 UNDERTAKER: Ebenezer Sun — ADDRESS: Chestnut St

INK—THIS IS A PERMANENT RECORD. Every item must be given in full. ...nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0947536

HEALTH DEPARTMENT—CITY OF BALTIMORE

0947536

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 Rutland Ave. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jacob Rupprecht,

(a) RESIDENCE. No. 1514 Rutland Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kathryn Ruppracht.

6 DATE OF BIRTH (month, day, and year) Nov. 4 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
46 -	46 -	11	20	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Trussed foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethelen Steel Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Christian Ruppracht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Barbara Germany

12 MAIDEN NAME OF MOTHER Barbara Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria Germany

14 Informant Geo Ruppracht
(Address) 1514 N. Rutland ave

15 Filed OCT 25 1920 19 ROBERT E ... Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 19 20

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1920, to Oct 24, 1920, that I last saw him alive on Oct 24, 1920, and that death occurred, on the date stated above, at 4 50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary hemorrhage.
30 minutes
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis
(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of May 10, 1920

Was there an autopsy? No

What test confirmed diagnosis? Abscess of Lung.

(Signed) Daniel Miller, M. D.

. 19 (Address) 1506 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 27 1920
20 UNDERTAKER	ADDRESS
Henry Lutz	1007 Bond St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Jr Fair 252 6-26th

47537 HEALTH DEPARTMENT—CITY OF BALTIMORE 47537

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1713 Guilford Ave ST. 17 WARD)

2-FULL NAME Ellen Asher

(a) RESIDENCE. No. 1713 Guilford Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widowed

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of William Asher

6 DATE OF BIRTH (month, day, and year) March 18 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	86	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER John Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth French

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John M Merritt (Address) 1713 Guilford Ave

15 Filed OCT 25 1920, 19... ROBERT B. ELLIOTT Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23rd 1920

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1920, to Oct 23rd, 1920, that I last saw her alive on Oct 21st 1920, and that death occurred, on the date stated above, at 1145 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

about (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) — yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. A. Fauv. M. D.

10/24 1920 (Address) 12 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greens Cemetery Sterner Run	Oct 26 1920
20 UNDERTAKER	ADDRESS
William Cook	502 E North

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47538

HEALTH DEPARTMENT—CITY OF BALTIMORE

104

D47538

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 329 Hchester Ave 1V WARD)

2-FULL NAME Catharine E. Ehrenworth

(a) RESIDENCE. No. 329 Hchester ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7 1920

7 AGE — Years: — Months: 9 Days: 17 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John R. Ehrenworth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Catharine Loy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Chase Md

14 Informant: John R. Ehrenworth (Address): 329 Hchester Ave

15 Filed OCT 25 1920, 19 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24th 1920

17 I HEREBY CERTIFY, That I attended deceased from October 22nd 1920, to October 24th 1920, that I last saw her alive on October 24th 1920 and that death occurred, on the date stated above, at 1730 P.M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Diab.

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo Thompson M. D

(Address) 4016 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Oct 26 1920

20 UNDERTAKER: William Cook — ADDRESS: 55 E North Ave

INSTRUCTIONS.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047539 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047539

CERTIFICATE OF DEATH.

118

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No Franklin Square Hospital ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma Davis

(a) RESIDENCE. NO. 801 W. Cross St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of William Davis

6 DATE OF BIRTH (month, day, and year) Oct 26 1847

7 AGE 53	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Leonard Belt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Gillett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William Davis
(Address) 801 W. Cross

15 Filed OCT 25 1920 19 ROBERT T. KRAUTER Registrar
RACHEL TURNER Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1920, to Oct 24, 1920
that I last saw h e alive on Oct 24, 1920
and that death occurred, on the date stated above, at 9.15 a. m.
The CAUSE OF DEATH* was as follows:

Chronic Pancreatitis

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) acute hemorrhagic Pancreatitis (duration) yrs. mos. 8 ds.

18 Where was disease contracted ?
If not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Lyman S. Abbott, M. D.

. 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Vault	Oct 27 1920
20 UNDERTAKER William Cook	ADDRESS 504 E Nork

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

0475'40

HEALTH DEPARTMENT—CITY OF BALTIMORE

0475'40

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Parrish St.; 16 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel Scribner

(Residence in Baltimore: No. 1102 Parrish St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)

7-AGE. 22 yrs. + mos. + ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Domestic 037
(b) General nature of industry, business, or establishment in which employed (or employer). Housework

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Sarah Hall

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Hall

(Address) 1102 Parrish St.

15-

Filed OCT 25 1920, 191.. ROBERT B KRAUTER

Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 22 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 9 1920, to Oct 22 1920, that I saw her alive on Oct 21 1920, and that death occurred, on the date stated above, at 11.25 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) — yrs. One mos. 12 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Charles E. Clark M. D.

Oct 23 1920 (Address) 1306 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Olivet

DATE OF BURIAL. Oct. 24, 1920

20-UNDERTAKER R. I. Parham

ADDRESS 1349 W Lee St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47541 — 104 D47541

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hyman Schreiber -

(Residence in Baltimore: No. Annapolis Md St.; ..... yrs., 8 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ~~Aug~~ August 21 1920
(Month) (Day) (Year)

7-AGE, ... yrs. 2 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Annapolis Md

PARENTS.

10-NAME OF FATHER, Hyman Schreiber

11-BIRTHPLACE OF FATHER (State or Country), Annapolis, Md

12-MAIDEN NAME OF MOTHER Jennie ?

13-BIRTHPLACE OF MOTHER (State or Country), ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) 1411 E. Balto

15- OCT 25 1920 ROBERT P. KRAUTER

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 24, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10/22 1920, to 10/24 1920, that I saw him alive on 10/24/ 1920 and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Marasmus -

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. R. Goldsborough M. D.

10/24, 1920 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. 2 mos. ..... ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence Annapolis, Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Olivet	Oct. 25, 1920.
20-UNDERTAKER	ADDRESS
Jack Levin	1411 E. Balto

(2-23) Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C. Beckerp.

047542 HEALTH DEPARTMENT—CITY OF BALTIMORE 047542

Gov of Thomas H.

CERTIFICATE OF DEATH. 169

1-PLACE OF DEATH REGISTERED NO. C.

CITY OF BALTIMORE (No. Baltimore Harbor ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME A. Beckerp

(Residence in Baltimore: No. Unknown St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ——— 1887
(Month) (Day) (Year)

7-AGE, 31 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Sailor
(b) General nature of industry, business, or establishment in which employed (or employer). Sea

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Lang

(Address) 1411 E. Bills St.

15- OCT 25 1920

Filed 5, 191 ROBERT F. KRAUTER

Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 25, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Synd Lincoln M. D.
(Coroner.)

Oct 25, 1920 (Address) 1600 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Rehoboth Cem. DATE OF BURIAL, 10-25 1920

20-UNDERTAKER Jackson, ADDRESS 1411 E. Bills

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47543 ✓ D 47543

CERTIFICATE OF DEATH.

105

1-PLACE OF DEATH W. Fayette St REGISTERED NO. C

CITY OF BALTIMORE: (No. Myerson ave & Rose's Lane ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thelma Smith

(Residence in Baltimore: No. Myerson ave & Rose's Lane St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, May (Month) 10 (Day), 1908 (Year)

7-AGE, 12 yrs. 5 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Louis L. Smith

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Lida Cronk

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lida Smith

(Address) Myerson Ave & Rose's Lane

15-

Filed OCT 25 1920, 191.. ROBERT E KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 17 1920, to Oct 23 1920, that I saw h[illegible] alive on Oct 23 1920, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Intestinal Intoxication

(Duration) ....yrs. ....mos. 6 ds.

(Signed) H. L. Smith M. D.

Oct 25, 191.. (Address) 409 W. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge	Oct. 26, 1920
20-UNDERTAKER	ADDRESS
Josiah Lytle	1100 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERMANENT RECORD

plied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47544

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 47544

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 N Broadway ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Elizabeth Smithey

(a) RESIDENCE. No. 1717 N. Broadway ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 3 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Late Chas E Smithey

6 DATE OF BIRTH (month, day, and year) July 3rd 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Benjamin Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cecil Co Md

12 MAIDEN NAME OF MOTHER Christianna Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Lydia M. Stees

(Address)

Filed OCT 25 1920 ROBERT E KRAUTER Registrar

Burial Permit Oct

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1920, to Oct 23, 1920, that I last saw her alive on Oct 22, 1920, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Chronic Gastritis OVER

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Gastritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C F Eaman, M. D.

10-23 1920 (Address) 1707 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 25th 1920
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47545 D 47545

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John aldridge

(Residence in Baltimore: No. University Hospital St.; yrs. 1 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mall

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct (Month) 3 (Day) 1883 (Year)

7-AGE, 37 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION: 886
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Farming

9-BIRTHPLACE, (State or Country) Virginia.

PARENTS.

10-NAME OF FATHER. J.W. aldridge

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER C. Giddings

13-BIRTHPLACE OF MOTHER (State or Country). Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. Fatyhugh

(Address) Westminster. Md

15- Filed OCT 25 1920, 191... ROBERT E KRAUTER Registrar.

Burial Permit Issued

Duplicate

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 24 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ...191..., to Oct. 24 1920, that I saw h[illegible] alive on Oct. 24 1920, and that death occurred, on the date stated above, at 1.15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach
operation

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W D Lewis M. D.

..., 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 28 ds. In the State about 1 mos. 14 ds.

Where was disease contracted, if not at place of death? Tallahasse, Fla.

Former or usual residence Tallahasse, Fla.

19-PLACE OF BURIAL OR REMOVAL, Annapolis Md — DATE OF BURIAL, Oct 26th, 1920.

20-UNDERTAKER Henry H. Jenkins Sons Co — ADDRESS McCaylor & Richard

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note that this information is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Nancy A. W. Nicholas

D 47546

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47546

CERTIFICATE OF DEATH.

X 74

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. John Carpenter St.: 7 WARD)

2-FULL NAME Miss Nancy Ann White Nicholas.

(a) RESIDENCE. No. Curings Mills Md ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If ~~married, widowed, or divorced~~ HUSBAND of (or ~~WIFE~~ of)

6 DATE OF BIRTH (month, day, and year) July 29 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Curings Mills Md.

PARENTS

10 NAME OF FATHER: Wilson Carey Nicholas

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Augusta Meade

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Mrs Wilson C Nicholas

(Address): Curings Mills Md

15 Filed OCT 25 1920 19.. ROBERT P. HAYNES Registrar

BUREAU VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 23 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22. 1920, to Oct. 23 1920, that I last saw h Er alive on Oct. 23 1920, and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) 7 yrs. - mos. - ds.

CONTRIBUTORY (Secondary) -

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Oct 23

Was there an autopsy? Yes

What test confirmed diagnosis? Operation.

(Signed) Emil H Holman M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Charles Pikesville Md	10-26 1920
20 UNDERTAKER Balto	ADDRESS Oxford
Henry W. Jenkins Sons Co	McCulloh

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

947547

HEALTH DEPARTMENT—CITY OF BALTIMORE

947547

CERTIFICATE OF DEATH.

X 90

REGISTERED NO. 8

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 E. North Ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth J. Manner

(a) RESIDENCE. No. 1613 E North Ave ST., WARD. Lynchburg Va

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of married

6 DATE OF BIRTH (month, day, and year) July 10, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 137

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lynchburg, Va

PARENTS

10 NAME OF FATHER Jno. J. Morrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Joanna Hurley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. A. G. Hungerford

(Address) 1613 E. North Ave

15 Filed OCT 25 1920 19 ROBERT B. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 18 1920, to Oct 25 1920, that I last saw h[illegible] alive on Oct 25 1920, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs only

(Signed) Wm. J. Watson, M. D.

Oct 25 1920 (Address) 212 E St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lynchburg, Va.	10/27/1920
20 UNDERTAKER	ADDRESS
George J. Reith.	1735 Hanford Ave

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

JULIANNA KOZLOWSA,

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47548

CERTIFICATE OF DEATH.

104 D47548

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2314 Cambrige ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julianna Kozlowska

(Residence in Baltimore: No. 2314 Cambridge St.: ....yrs., 3 mos. ....ds.)

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should take particular care that this information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	+

6-DATE OF BIRTH, ...July.... (Month) 20 th- (Day), 1920. (Year)

7-AGE, ...3.... yrs. ....4.... mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....0.....
(b) General nature of industry, business, or establishment in which employed (or employer).....000.....

9-BIRTHPLACE, (State or Country) Baltimore, Md.,

PARENTS:

10-NAME OF FATHER, Joseph Kozlowski,

11-BIRTHPLACE OF FATHER (State or Country), Poland,

12-MAIDEN NAME OF MOTHER Alexandria Boracka,

13-BIRTHPLACE OF MOTHER (State or Country), Poland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Kozlowski,

(Address) 2314 Cambrige Street

15- Filed OCT 25 1920 191... ROBERT E KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 24, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 19 1920, to Octob 24 1920, that I saw h- alive on Octob 24 1920, and that death occurred, on the date stated above, at 3 30 p.m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) ....yrs. 5 mos. 7 ds.

CONTRIBUTORY (Secondary) Diarrhea

(Duration) ....yrs. 5 mos. 7 ds.

Oct 24 (Signed) M. Jaworzyn M. D.

Oct ....., 1920 (Address) 2431 Fawn St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary.	OCT. 25 1920
20-UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Ann St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 47549

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47549

CERTIFICATE OF DEATH.

105

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 518 Orchard ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes L. Queen

(Residence in Baltimore: No. 518 Orchard St.: 12 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug (Month) 3 (Day), 1881 (Year)

7-AGE, 39 yrs. 2 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Waitress
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Jas H. Gales

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Emily Barnes

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas H. Queen

(Address) 518 Orchard

15-

Filed....., 191.....

OCT 25 1920 ROBERT B KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 20 1920, to Oct 23 1920, that I saw h[illegible] alive on Oct 23 1920, and that death occurred, on the date stated above, at 7.10 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration).....yrs.....mos. 6 ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) William E Burlen M. D.

Oct 23..., 1920. (Address) 762 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Alford Md — DATE OF BURIAL, Oct. 25 1920

20-UNDERTAKER Samuel T Hemelup — ADDRESS 5781 W Biddle

CAUSE OF DEATH information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047550 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047550

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH
S.W. Cor. Madison & Monument Sts.
CITY OF BALTIMORE: (No. Carnegie Institute of Embryology ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Backert

(a) RESIDENCE. NO. 612 S. Rose ST., 1st WARD.
(Usual place of abode)
Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or 30 min.
—	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) abnormal infant

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Andrew Backert

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Rose Weber

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Rose Weber Backert
(Address) 612 S. Rose St.

15 Filed OCT 25 1920 ROBERT E. KRAUTER
Registrar
Burial Permit O'Hara

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1920, to Oct 25, 1920, that I last saw her alive on Oct 25, 1920, and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Abnormality - Monster
(acrania)

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? (?) mid wife

What test confirmed diagnosis? —

(Signed) H. M. Wright, M. D.

Oct 25 1920 (Address) 3018 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Carnegie Institute of Embryology
John Hopkins Med. School

DATE OF BURIAL
19

20 UNDERTAKER

ADDRESS

INSTRUCTIONS

This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0475'51

HEALTH DEPARTMENT—CITY OF BALTIMORE

0475'51

151

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Poppleton

CITY OF BALTIMORE: (No. 117 S. ~~Fankin~~ ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Rachels

(a) RESIDENCE. No. 117 S. Poppleton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Oct 21- 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2½	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None ooo

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Ray Rachels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Gertrude Tawney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cumberland Maryland

14 Informant Mrs Gertrude Rachels

(Address) 117 S Poppleton St

15 Filed OCT 25 1920 ROBERT E. LEATHER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24th 1920.

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1920, to Oct 24, 1920, that I last saw him alive on Oct 24, 1920, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(34 weeks foetus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Rease, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peter's Cem	Oct 25th 1920
20 UNDERTAKER John Howard & Son	ADDRESS for Hollins St

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47552

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47552

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 18 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Hill

(a) RESIDENCE. No. 246 N. Schroeder St. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Maggie Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records (Address) M.T.H.

15 Filed OCT 25 1920 ROBERT F KRAUTER Registrar

Racial Farmt Olerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1920

17 I HEREBY CERTIFY, That I attended deceased from October 11, 1920, to Oct. 24, 1920, that I last saw him alive on Oct. 23, 1920, and that death occurred, on the date stated above, at 8 a.m. The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray.

(Signed) L J Rigney, M. D.

10-24-20, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Taneytown Md	Oct 26 19 20
20 UNDERTAKER A. Jones	ADDRESS 2178 Stricker St

REMEMBER IT IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 47553 HEALTH DEPARTMENT—CITY OF BALTIMORE D 47553

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 800 N. Kenwood ST.; 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth McKee

(a) RESIDENCE. No. 808 N. Kenwood ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17, 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Marion McKee (Address) 800 N. Kenwood

15 Filed OCT 25 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1920, to Oct 25, 1920, that I last saw h[illegible] alive on Oct 24, 1920, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Uremia Coma

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Int. Nephritis + Debility (duration) 2 yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical dia

(Signed) A B Lemmon, M. D.

10/26/20 (Address) 718 N Dallison Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Oct 27 1920
20 UNDERTAKER Zurklert & Zirkler	ADDRESS 1739 E Eager

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.47554 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47554

CERTIFICATE OF DEATH. 9-091

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lyderham Hospital St. or Ward)

2-FULL NAME Theodore Wm. Peters

(a) RESIDENCE. No. 203 S. Payson ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 1 yrs. 6 mos. 19 ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) april 5-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md.

PARENTS

10 NAME OF FATHER Theodore W. Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md.

12 MAIDEN NAME OF MOTHER Julia Eylkeston Oct. 25 1920 Address Lyderham Hospital

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Thos. Eylkeston (Address) 2025 Payson

15 Filed OCT 25 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1920, to Oct 21, 1920, that I last saw him alive on Oct 21, 1920, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) — yrs. — mos. 13 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? positive diphtheria culture.

(Signed) A. MacGowan, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	10/25 1920
20 UNDERTAKER H. H. Nitzke	ADDRESS 1531 W Lombard

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.47555

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47555 151 D.47555

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. Hudson Heights St.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Munk

(Residence in Baltimore: No. Hudson Heights St.; ..... yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms. AGE should be stated EXACTLY. Omissions should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very properly classified.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	White	Single

6-DATE OF BIRTH, Oct (Month) 24 (Day), 1920 (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 5 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Edward P. Munk

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Marie Robb

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward P. Munk

(Address) 1606 E. Balto St.

15- Filed ....., 191.... Registrar.

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 24 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 24 1920, to Oct 24 1920, that I saw h[illegible] alive on Oct 24 1920, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Instantaneous

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Chas. Geo. Guy M. D.

Oct 25, 1920 (Address) 1606 E. Balto St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Lehnards	Oct 25 1920
20-UNDERTAKER	ADDRESS
Kendall Oppelt	37 S. [illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14370 D.47556 — D.47556

1-PLACE OF DEATH

91-151

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ardath Reesey.

(a) RESIDENCE. No. 3526 Myrtle Place Baltimore MD. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 17-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Virgil Reesey.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Pauzy Washer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania

14 Informant ....
(Address)

15 Filed OCT 25 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 9, 1920, to Oct. 23, 1920, that I last saw h[er] alive on Oct 23, 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) ....yrs. ....mos. 25 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ....Date of ....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W C Davison, M. D.

, 19 (Address) J H H Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	10/26 1920
20 UNDERTAKER J. J. Moran	ADDRESS 300 E Balto

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Every item of information is very important. See instructions on back of certificates. PHYSICIAN should state it may be properly classified. Exact statement of OCCUPATION

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.47557

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.47557
64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A Malone

(a) RESIDENCE. NO. 422 N Linwood ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jas. L. Malone.

6 DATE OF BIRTH (month, day, and year): Aug - 1887

7 AGE: Years 33 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West Enguma

PARENTS

10 NAME OF FATHER: J. H. Dempsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Agt Lonan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Jas. L. Malone 422 N. Linwood ave

15 Filed, 19 Robert P. Harrison, Registrar

OCT 25 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/22 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1920, to Oct. 22, 1920, that I last saw h[er] alive on October 22, 1920, and that death occurred, on the date stated above, at 2.50 P m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

4 hrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Chas. O Doran M. D.

, 19 (Address) 6-E-Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 10/26 1920

20 UNDERTAKER: J. A. Doran

ADDRESS 300 E Baltimore

INSTRUCTIONS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

D.47558 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47558

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 26 N. Hare ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Coughlin

(a) RESIDENCE. No. 26 N. Hare ST., 6 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 23-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Louis F. Coughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Anna M. Jamison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Louis F. Coughlin
(Address) 26 N. Hare St.

15 Filed OCT 25 1920 19 Robert P. Harrison, Registrar
(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/23- 19 20

17 I HEREBY CERTIFY, That I attended deceased from 10/23/20 19 , to 10/23/20 19 , that I last saw h alive on 10/23/20 19 , and that death occurred, on the date stated above, at 11 P.M. The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) mucr.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) + Fredrick Wyneman M. D.

(Address) 2919 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	10/ 1920

20 UNDERTAKER J. A. Moran ADDRESS 3000 E. Balto.

Warning should be carefully supplied. AGE should be stated EXACTLY in every item of information. CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.47559 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47559

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 743 Sarah ann st. 4 WARD) REGISTERED NO. C. 119

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Cornish

(Residence in Baltimore: No. 743 Sarah ann st, St. 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: ..... (Month) Sept (Day) ..., 1892 (Year)

7-AGE: 28 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Lab

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Don't Know

11-BIRTHPLACE OF FATHER (State or Country): " " "

12-MAIDEN NAME OF MOTHER: " " "

13-BIRTHPLACE OF MOTHER (State or Country): " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) JAMES H. DENNIS

(Address) 1303 PRESTMAN ST.

15- Robert P. Harrison,

Filed ..., 192..., 191... Registrar.

OCT 25 1920 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct (Month) 23 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (~~Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said..... (~~Coroner, au~~topsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis (from History)

(Duration) ... yrs. ... mos. 5 ds.

CONTRIBITORY (Secondary) Don't Know of any

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D. (Coroner.)

10/25 1920 (Address) 117 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Oct 26 1920

20-UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47560 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47560

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 39 Bilsaw Ave ST.; 27 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marianna Maria Todaro

(Residence in Baltimore: No. 34 Aliceanne St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
fem	white	

6-DATE OF BIRTH, 10-4-20, 1 (Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 19 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....000....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Andrew Todaro

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Mary Pertsch

13-BIRTHPLACE OF MOTHER (State or Country), Italy Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Todaro

(Address) 32 Carlton Ave

15- Filed OCT 25 1920, 191.... Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10-23-, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-22- 1920, to 10-23- 1920, that I saw her alive on 10-23 1920, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

gastro enteritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Tobi Nerbo M. D.

....., 191... (Address) 210 Bearl St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Oct 23, 1920

20-UNDERTAKER	ADDRESS
Leo Eisbock	Eutaw Place

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.47561

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D.47561

1 PLACE OF DEATH — REGISTERED No. C 29

CITY OF BALTIMORE (No. 1641 Tenth St. ST 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Almira Virginia Glanding

(Residence in Baltimore: No. 1641 Tenth St. St. 15 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: March (Month) 6 (Day), 1845 (Year)

7 AGE: 75 yrs. 7 mos. 18 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9 BIRTHPLACE (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Henry Hildebrandt

11 BIRTHPLACE OF FATHER (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Achsah Ann Marriott

13 BIRTHPLACE OF MOTHER (State or country): Louisville, Ky.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carrie V. Glanding

(Address) 1641 Tenth St. Baltimore Md.

15 Filed OCT 25 1920, 191 — Robert P. Harrison, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. (Month) 24 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1920 to Oct 24, 1920, that I saw h er alive on Oct 24, 1920 and that death occurred, on the date stated above, at 3.35 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Vernon H. Condon M. D.

Oct 25, 1920 (Address) 730 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Western Cemetery — DATE OF BURIAL: Oct 27, 191

20 UNDERTAKER: George J Smith — ADDRESS: Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.47562 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.47562

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 N. Gilmor ST.: 19 WARD)

2-FULL NAME Harriet Virginia Hargadon

(a) RESIDENCE. No. 19 N. Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 1 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bryan Hargadon

6 DATE OF BIRTH (month, day, and year) July 26, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 600

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Thomas Hohn

11 BIRTHPLACE OF FATHER (city or town) Harford Co (State or country) Md

12 MAIDEN NAME OF MOTHER Harriet Chalk

13 BIRTHPLACE OF MOTHER (city or town) Harford Co (State or country) Md

14 Informant Harry E. Hargadon

(Address) 630 S. Payson St.

15 Filed OCT 25 1920, 19.. Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1920

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to Oct 23, 1920, that I last saw h. alive on Oct 22, 1920, and that death occurred, on the date stated above, at 3, 15 a m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) M. O'Neill, M. D.

10/23. 1920 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	Oct 26 1920
20 UNDERTAKER George J Smith	ADDRESS 1400 N. Fayette st

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47563

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47563

X 51-091

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. Phipps Clinic ST.; East WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella C. Martin

(Residence in Baltimore: No. Johns Hopkins Hospital, Baltimore Md St.; ..... yrs., ... mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, January (Month) 9 (Day), 1880 (Year)

7-AGE, 40 yrs. 9 mos. 16 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Nurse ...
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Housework ...

9-BIRTHPLACE, (State or Country), Maryland, Harford Co.

PARENTS.

10-NAME OF FATHER, J. Chapman Martin

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Cornelia Lee

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lulie B. Holeman

(Address) Johns Hopkins Hospital

15-

OCT 25 1920 Robert P. Harrison,

Filed ....., 191..... Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 25 (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 7 1920, to Oct. 25 1920, that I saw her alive on Oct. 25 1920, and that death occurred, on the date stated above, at 10.15 A.M.

The CAUSE OF DEATH* was as follows:

..... Graves Disease .....

.....

.....

..... (Duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. 1 .... ds.

(Signed) Ruth E. Fairbank M. D.

Oct. 25, 1920. (Address) Johns Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 19 ds. In the State 40 yrs. 9 mos. 16 ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence Aberdeen Md (Harford Co.)

19-PLACE OF BURIAL OR REMOVAL, Aberdeen Md. | DATE OF BURIAL, Oct. 25., 1920.

20-UNDERTAKER Wm Tickner & Son | ADDRESS North & Penna Ave

ACCURACY. PHYSICIANS should state ACCURATELY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47564

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47564

CERTIFICATE OF DEATH.

108

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 905 S Howard ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gussie Harris

(a) RESIDENCE. NO. 905 S. Howard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
abt	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home.

(b) General nature of Industry, business, or establishment in which employed (or employer) 500

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Isaella Harris

11 BIRTHPLACE OF FATHER (city or town) Talbott Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Harris

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Carrie Haley

(Address) 1043 N Lexington

15 Filed ..... 19.....

Robert P. Harrison, Registrar

OCT 25 1920

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- Every item of information

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/24/ 1920

17

I HEREBY CERTIFY, That I attended deceased from 10/22/ 1920, to 10/24/ 1920,

that I last saw her alive on 10/24/ 1920,

and that death occurred, on the date stated above, at 1.15 a m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis 0/24

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) General Peritinitis.

(duration) ....yrs. ....mos. 8 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) E. Jno Bowley, M. D.

10/24/20 (Address) 908 S Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Oct 26 1920

20 UNDERTAKER William Cook

ADDRESS 504 E Baltimore Ave

D.47565

HEALTH DEPARTMENT--CITY OF BALTIMORE

D.47565

CERTIFICATE OF DEATH

28

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Kernans Hospital School St. 28 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles Hollis.

(Residence in Baltimore: No. Kernans Hospital School St.: 1 yrs. 5 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	white	Single

6 DATE OF BIRTH: March (Month) 6 (Day), 1911 (Year)

7 AGE: 9 yrs. 7 mos. 18 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none 000
(b) General nature of industry, business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): West Virginia

PARENTS

10 NAME OF FATHER: Chas Hollis.

11 BIRTHPLACE OF FATHER (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Malinda Slaughoff

13 BIRTHPLACE OF MOTHER (State or country): W Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo H Grove

(Address) Kernans Hospital

15 Filed OCT 25 1920, 191 — Robert P. Harrison, Burial Permit Clerk — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October (Month) 24 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1919, to Oct 24 1920, that I saw him alive on Oct 24, 1920, and that death occurred, on the date stated above, at 7.40 P.M.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration) 2 yrs. ..... mos. ..... ds

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo H. Grove M. D.
Oct 24, 1920 (Address) Kernans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death 1 yrs. 5 mos. 12 ds. In the State 1 yrs. 5 mos. 12 ds.
Where was disease contracted, if not at place of death? Martinsburg W Va
Former or usual residence Martinsburg W. Va

19 PLACE OF BURIAL OR REMOVAL: Martinsburg - W. Va — DATE OF BURIAL: Oct 26 1920

20 UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

20.47566

HEALTH DEPARTMENT--CITY OF BALTIMORE.

CERTIFICATE OF DEATH

20.47566

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 610 Wyanoke Ave ST.: 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Baily Lewis

(Residence in Baltimore: No. 610 Wyanoke Ave ... Single yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: January 6, 1880 (Month) (Day) (Year)

7 AGE: 40 yrs. 8 mos. 19 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Machinist 031
(b) General nature of industry, business, or establishment in which employed (or employer): Can Factory

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: James M. D. Lewis

11 BIRTHPLACE OF FATHER (State or country): Somerset Co Md.

12 MAIDEN NAME OF MOTHER: Ann E Bailey

13 BIRTHPLACE OF MOTHER (State or country): Baltimore Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Kendle M Lewis
(Address): 611 E. Preston St

15 Filed OCT 25 1920, 191 — Robert P. Harrison, REGISTRAR
Burial Permit Clerk.

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 25 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 22 Oct, 1920, to 26 Oct 1920, that I saw him alive on 25 Oct, 1920, and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ... yrs. ... mos. 2 ds

Contributory (SECONDARY) Hypertrophied Heart (Duration) ... yrs. ... mos. 4 ds.

(Signed) D. Dr. Smyth M. D.

25 Oct, 1920 (Address) 301 S Elwood Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Oct 25, 1920

20 UNDERTAKER: H C Hughes — ADDRESS: 17 N Broadway

1047567 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047567

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 1120

CITY OF BALTIMORE (No. 1547 Argyle Ave ST.: ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachael A. Parker

(Residence in Baltimore: No. 1547 Argyle Ave St.; yrs. 30 mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May ?, 1875 (Month) (Day) (Year)

7-AGE. 45 yrs. 5 mos. ? ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Benj. Smallwood

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ellen Douglass

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Parker

(Address) 1547 Argyle Ave

15- OCT 26 1920 Filed ..., 191... ROBERT P. KRAUTER Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 23, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ... yrs. 1 mos. ... ds.

(Signed) C. J. Heitmuller M. D. (Coroner.)

Oct. 25, 1920 (Address) 780 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Oct 28, 1920

20-UNDERTAKER Barnes & Wright ADDRESS 1364 Mary

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state exact nature of information should be carefully supplied. ACE should be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D4 7568 HEALTH DEPARTMENT—CITY OF BALTIMORE D47568

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 E 22nd ST.: 9th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothea Emma Gosnell

(a) RESIDENCE. No. 527 E 22nd ST., 9th WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James L Gosnell, husband

6 DATE OF BIRTH (month, day, and year) Oct. 10, 1887.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chicago, Ill.

PARENTS

10 NAME OF FATHER Henry F Bowyer

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Verburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant Henry F Bowyer (Address) 527 E. 22nd St.

15 Filed OCT 26 1920 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 20, to Oct 24, 1920, that I last saw her alive on Oct 24, 1920, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) many years mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) H L Kaiser, M.D.

, 19 (Address) Wolfe and Monument Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Oct 27 1920
20 UNDERTAKER	ADDRESS
E A Friedgen Jr	501 E 25th St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47569

CERTIFICATE OF DEATH.

10 D47569

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gnirral Hospital ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Monroe Watson Boldson.

(a) RESIDENCE. NO. Ellicott City ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 7 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Ella Oakland Maryland

PARENTS

10 NAME OF FATHER Frederick Boldson

11 BIRTHPLACE OF FATHER (city or town) Grays Balt Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maud Mary McKenzie

13 BIRTHPLACE OF MOTHER (city or town) Ellicott City (State or country) Maryland

14 Informant Frederick Boldson
(Address) Ellicott City Md

15 Filed OCT 26 1920 . 19 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 25 1920.

17 I HEREBY CERTIFY, That I attended deceased from October 16 . 1920. , to October 25 . 1920 .
that I last saw him alive on October 25 . 1920 .
and that death occurred, on the date stated above, at 12.30 p. m.
The CAUSE OF DEATH* was as follows:

Myrasmus.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.
Did an operation precede death? No. Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Examinations.

(Signed) H. Wilbur Stewart, M. D.
10/26 1920 (Address) Maryland Gnirral Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Johns Howard Co Md	Oct 26 1920
20 UNDERTAKER Easton Sons	ADDRESS Ellicott City

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~D 47570~~ 78 D 47570

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B. Wright.

(a) RESIDENCE. No. 1341 Mosher ~~Street~~ ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Roberta Wright

6 DATE OF BIRTH (month, day, and year) 2. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter at Hosp

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Johns Hopkins Hosp

15 Filed OCT 20 1920 ROBERT B. LITTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1920, to Oct. 24, 1920, that I last saw h~~im~~ alive on Oct. 24, 1920, and that death occurred, on the date stated above, at 5.45 P.m.

The CAUSE OF DEATH* was as follows:

Malignant Endocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R Mason, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loretto King & Queen Co Va — DATE OF BURIAL: Oct 26 1920

20 UNDERTAKER: George H. Holland — ADDRESS: 163 Kenwood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

47571

HEALTH DEPARTMENT—CITY OF BALTIMORE

No. 47571

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME H. Irving Riddle Jr.

(a) RESIDENCE. NO. 1019 W. 37th St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12, 1918

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
2	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER H. Irving Riddle

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Hattie Frock

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant H. Irving Riddle

(Address) 1019 W. 37th St.

15 Filed OCT 26 1920 ROBERT I. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23, 1920

17 I HEREBY CERTIFY, That I attended deceased from 10-22-, 1920, to 10-23-, 1920, that I last saw him alive on 10-23, 1920, and that death occurred, on the date stated above, at 10:00 P. m.

The CAUSE OF DEATH* was as follows:

Intussusception

(duration) yrs. mos. 7 hrs. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-22-20

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Surgical Findings

10/24. 1920 (Signed) [illegible], M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Oct 26 1920
20 UNDERTAKER Jos. B. Cook	ADDRESS 1023 W. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047572 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047572

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 16 W Madison St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Matilda Baetjer

(a) RESIDENCE. No. 16 W Madison St.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Geo. Baetjer

6 DATE OF BIRTH (month, day, and year) March 25, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER John G. Koppelmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Grauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) Walter A Baetjer 16 W Madison St

15 Filed OCT 26 1920 ROBERT F KRAUSER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1920

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1920, to Oct 24, 1920, that I last saw h alive on Oct 23, 1920, and that death occurred, on the date stated above, at 2 30 a. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos. R. Boggs, M. D.

, 19 (Address) 21 West Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Oct 26 1920
20 UNDERTAKER	ADDRESS
Henry W. Justice Sons & C	10 Cullom Orchard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0947573

HEALTH DEPARTMENT—CITY OF BALTIMORE

0947573

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 Edgevale Road R.F. St.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen J. Stewart

(a) RESIDENCE. No. 212 Edgevale Rd R.F. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~ (write the word): Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of: Alexander D. Stewart

6 DATE OF BIRTH (month, day, and year): 1838-11-14

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Walter Fraser

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Ellen Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Mrs. Chas. W. Stebbins
(Address): 202 Edgevale Road

15 Filed OCT 26 1920, 19 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1920, to Oct 24, 1920, that I last saw her alive on Oct 24, 1920, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
Gall-bladder

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary): Tapioca

(duration) ..... yrs. ..... mos. 25 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopical Examination

(Signed) W W Leppard M. D.

, 19 (Address) 805 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Oct 27 1920
20 UNDERTAKER: Henry J. Jenkins Sons Co	ADDRESS: McCulloh & Richard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D475574 HEALTH DEPARTMENT—CITY OF BALTIMORE D475574

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2328 Flet ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Podlesny

(a) RESIDENCE. NO. 2328 Flet ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Podlesny

6 DATE OF BIRTH (month, day, and year) Oct. 15 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) Poston (State or country) Poland

PARENTS

10 NAME OF FATHER Steven Wysogrowski

11 BIRTHPLACE OF FATHER (city or town) Wielgie (State or country) Poland

12 MAIDEN NAME OF MOTHER ? ~~Wysogrowski~~

13 BIRTHPLACE OF MOTHER (city or town) Wielgie (State or country) Poland

14 Informant Adam Podlesny (Address) 2328 Filet st

15 Filed OCT 26 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25 / 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1920, to Oct. 25, 1920, that I last saw her alive on Oct. 25, 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Scurvy

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Philibert Artigiani M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 27 1920

20 UNDERTAKER John B Weber ADDRESS 1803 Bank st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... state TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47575

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47575

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Johnson

(a) RESIDENCE. No. 741 Ajax St. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) day

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Ned Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed OCT 26 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 23, 20

17 I HEREBY CERTIFY, That I attended deceased from October 16, 1920, to October 23 1920, that I last saw him alive on October 23, 1920, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. mos. 2 1 ? ds.

CONTRIBUTORY (Secondary) Secondary anemia

* Cachexia (duration) yrs. mos. 2 1 ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 10-15-20.

Was there an autopsy? no.

What test confirmed diagnosis? Exp. Laparatomy

(Signed) J. A. Holden, M. D.

10/24/1920 Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cmtry	Oct 26 '20
20 UNDERTAKER	ADDRESS
Mrs Robert Elliott	Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

0475 76

HEALTH DEPARTMENT—CITY OF BALTIMORE

0.475 76

CERTIFICATE OF DEATH.

REGISTERED No. C 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 N Carey ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Myers

(Residence in Baltimore: No. 713 N Carey St.; 86 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, April 8, 1834
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
86 yrs. 6 mos. 15 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Cox

(Address) 713 N. Carey

15-

Filed OCT 26 1920, 191.... ROBERT B KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 23, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 22 1920, to Oct 22 1920, that I saw h er alive on Oct 22 1920, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

~~Acute~~ Myocarditis

(Duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Joseph E. Myers M. D.

Oct 24, 1920 (Address) 1520 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Western Cem	Oct 26, 1920

20-UNDERTAKER	ADDRESS
Thos A & J Robb	1613 Eutaw Pl

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47577 HEALTH DEPARTMENT—CITY OF BALTIMORE D 47577

CERTIFICATE OF DEATH. X 53

1-PLACE OF DEATH Md Gen Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No. Madison & Linden ST.: 11 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Makeman Jourdan

(a) RESIDENCE. NO. Conowingo Md ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Jourdan

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER Charles Jourdan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Wm H. Bowen (Address) Conowingo Md

15 Filed OCT 26 1920, 19 ROBERT B BRAUER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 11. 20, 19..., to Oct 26, 1920, that I last saw him alive on Oct 26, 1920, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Splenic Leukaemia

opp.
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Conowingo

Did an operation precede death? Yes Date of Oct 19. 20

Was there an autopsy? No

What test confirmed diagnosis? Operation & Symptoms

(Signed) W. F. Tyler Jones M.D.

, 19 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockland Harford Co Md — DATE OF BURIAL Oct 28 1920

20 UNDERTAKER John F Denny — ADDRESS 715 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 47578

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47578

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Morrison Court St.; 25 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Manuel Blumson

(Residence in Baltimore: No. 1416 Morrison Court St.; ..... yrs., 10 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Infant

6-DATE OF BIRTH, August 29, 1919
(Month) (Day) (Year)

7-AGE, 1 yrs. 1 mos. 27 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Pennsylvania

PARENTS.

10-NAME OF FATHER David Blumson

11-BIRTHPLACE OF FATHER (State or Country) Russia

12-MAIDEN NAME OF MOTHER Nellie Bernstein

13-BIRTHPLACE OF MOTHER (State or Country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Blumson

(Address) 1416 Morrison Court

15- ROBERT B LEAUTER

Filed ....., 191.... Registrar. Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 25 1920, to Oct 25 1920, that I saw h[illegible]alive on Oct 25 1920, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) ..... ooo

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B. Harlan M. D.

Oct 26th, 1920 (Address) Reedar & Pitt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 1416 Morrison Court

19-PLACE OF BURIAL OR REMOVAL, Pulaski Road-Rosedale

DATE OF BURIAL, Oct 27, 1920

20-UNDERTAKER Levison

ADDRESS 112 E Baltimore

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47579

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47579

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH Mt Hope Retreat

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 714 S. Milton ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Revicka

(Residence in Baltimore: No. ~~Mt Hope Retreat~~ 714 S Milton Ave. St.; 22 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Not Known ....., 1 .....
(Month) (Day) (Year)

7-AGE, abt 24 yrs. 0 mos. 0 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Car Builder
(b) General nature of industry, business, or establishment in which employed (or employer) R.R.

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, William Revicka

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Julia Dora

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Records of Mt Hope Retreat

(Address) Baltimore -

15-

Filed Oct 26 1920, 191.....

Robert P. Harrison,
Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 25, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 25 1920, to Oct 25 191, that I saw h... alive on Oct 25 191, and that death occurred, on the date stated above, at X 3 m.

The CAUSE OF DEATH* was as follows:

Paresis

abt (Duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)
Hypertension (Duration) 0 yrs. 2 mos. 0 ds.

(Signed) Frank J Flannery M. D.

....., 191... (Address) Mt Hope Retreat

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 2 mos. ds. In the State Dont Know yrs. mos. ds.

Where was disease contracted, if not at place of death? Probably Baltimore

Former or usual residence Baltimore -

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Stanislaus Cem	Oct 27..., 191..
20-UNDERTAKER	**ADDRESS**
Stephen Kwiatkowski	100 S Kenwood Ave

If not important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47580 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47580

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C 113

CITY OF BALTIMORE: (No. 2216 Druid Hill ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilhelmina P. Carter

(Residence in Baltimore: No. 2216 Druid Hill Ave St.; Fifty yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Mar 16 (Month), (Day), 1869 (Year)

7-AGE, 51 yrs. 7 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, David Pinkett

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Margaret Bennett

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Moriah T. Pinkett

(Address) 2216 Druid Hill Ave

15-

Filed OCT 26 1920, 191 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 25th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 13th 1920, to Oct 25th 1920, that I saw h[er] alive on Oct 24th 1920, and that death occurred, on the date stated above, at 7.45 A. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the liver

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) not known

(Duration) yrs. mos. ds.

(Signed) Chas. Keller M. D.

Oct 26, 1920 (Address) 2216 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cmty — DATE OF BURIAL, Oct 28, 1920

20-UNDERTAKER George H. Holland — ADDRESS 1631 Druid Hill Ave

important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.47581 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47581

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1922 Gough St. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Mayerhrzak

(a) RESIDENCE. NO. 1922 Gough St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Wht

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE Years 70 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer Poland

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Ignatius Mayerhrzak

(Address) 1922 Gough St.

15 Filed , 19 Registrar

OCT 26 1920

Robert F. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 22 19 W, to Oct 25 19 W

that I last saw h alive on Oct 25 19 20 and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Wyroom M. D.

Oct 25 20 (Address) 601 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL N. Stanislaus. DATE OF BURIAL Oct 27" 1920

20 UNDERTAKER W. F. Sadowski, ADDRESS 905 S. Conn

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state exact disease of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47582 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47582

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 604 So. Ann ST.: 2nd. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARY POPIOLEK,

(a) RESIDENCE. No. 604 So. Ann ST., 2 nd. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIAN should state what it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stanislaus Popiolek,

6 DATE OF BIRTH (month, day, and year) Unknown. 1869.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife, 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER Wojciech Filipowicz,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Eliszabeth Szymanski,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Stanislaus Popiolek. (Address) 604 So. Ann Street

15 Filed 10/28 1920 19 Robert P. Harrison, Registrar

10/28 1920 Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25. 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1920. to Oct 25, 1920.

that I last saw her alive on . . , 1920.

and that death occurred, on the date stated above, at 2.00 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. J. Freidam, M. D.

10/26. 1920 (Address) 918 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus. DATE OF BURIAL: Oct 28" 1920

20 UNDERTAKER: M. J. Sadowski. ADDRESS: 905 S. Linn

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47583 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47583

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William G. Wamsley

(a) RESIDENCE. NO. 5106 Grove Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Dec 25 1848

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
72	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed ..., 19 ... Registrar

10/26/1920

Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 25 1920

17 I HEREBY CERTIFY, That I attended deceased from October 22, 1920 to October 25, 1920 that I last saw him alive on October 25, 1920 and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uhyocardial insuf-ficiency (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? No especial test.

(Signed) V. Bateman, M. D.

(Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Oct 27 1920
20 UNDERTAKER (Firkler & Firkler)	ADDRESS 1739 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47584 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47584

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 N Regester ST.; 8 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John William Lessner

(Residence in Baltimore: No. 1610 N Regester St.; ....yrs., 1 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Infant

6-DATE OF BIRTH, Sept 26, 1920.
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Infant Son

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William Lessner

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Elizabeth Westerhoff

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William M. Lessner

(Address) 1610 N. Regester St.

15-

Filed OCT 26 1920, 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 26 1920, to Oct 20 1920, that I saw him alive on Oct 25 1920, and that death occurred, on the date stated above, at 12¼ am.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency & Collapse
& Acute Endocarditis

(Duration) ....yrs. 1 mos.....ds.

CONTRIBUTORY (Secondary) Tetanus of Umbilicus Valve to Close at time of Birth

(Duration) ....yrs. 1 mos.....ds.

(Signed) L. D. Layman M. D.

Oct 26 1920 (Address) 1701 N Caroline St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Oct 27, 1920.

20-UNDERTAKER Robt F Turner & Son ADDRESS 442 N Broadway

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47585 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47585

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary REGISTERED NO. C.....

CITY OF BALTIMORE: (No. North Broadway ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Babka

(Residence in Baltimore: No. 1101 Cookie St. St.; 4 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June 18, 1911
(Month) (Day) (Year)

7-AGE, 9 yrs. 4 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James J. Balka

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Elizabeth E. Hengebauer

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James J. Babka

(Address) 1101 Cookie

15-

OCT 26 1920 Filed....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 25, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 22 1920, to Oct. 25 1920, that I saw her alive on Oct. 25, 1920, and that death occurred, on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:

Infected Wound, Face, right
Lobar Pneumonia
Septicemia

(Duration)..... yrs. ..... mos. 4 ds.

CONTRIBUTORY.....
(Secondary)

(Duration)..... yrs. ..... mos. ..... ds.

(Signed) Walter T. Anderson M. D.

Oct. 25, 1920 (Address) Church Home & Inf.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 ds. In the State 9 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 1101 Cookie St, City

Former or usual residence 1101 Cookie St, Baltimore, Md.

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, Oct. 28, 1920

20-UNDERTAKER E. Schloman & Son ADDRESS 1039 Hanover St

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec. 6-9-19—H. P. Co.—1000 Blks.

D.47586 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47586

81

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Aged Mens Home (St.) 19 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Garon Nutt

(a) RESIDENCE. No. 1400 W Lexington St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wht	Wid.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Dec.? 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pemberton N. J.

PARENTS

10 NAME OF FATHER Ben R Nutt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pemberton N. J.

12 MAIDEN NAME OF MOTHER Ellen E Garon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pemberton N. J.

14 Informant H. W. Gilman (Address) Motor

15 Filed OCT 26 1920, 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1920

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1920, to Oct 26, 1920, that I last saw h alive on Oct 25, 1920, and that death occurred, on the date stated above, at 3 20 A m.

The CAUSE OF DEATH* was as follows:

General Arterial Sclerosis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? None

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

(Address) 909 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
North East. Cem. Co.	Oct 27, 1920
20 UNDERTAKER George J. Smith.	ADDRESS 1917 Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.47587

Spec. 6-9-19—H. P. Co.—1000 Bks.

D47587 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 89

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 839 N. 34th. ST.; 13 WARD)

2-FULL NAME Robert P. Maxwell

(a) RESIDENCE. No. 839 N. 34th St. ST., 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 10- 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	11	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant 145
(b) General nature of industry, business, or establishment in which employed (or employer) Retired 30 years.
(c) Name of employer

9 BIRTHPLACE (city or town) Govans.
(State or country) Md.

PARENTS

10 NAME OF FATHER John Maxwell

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs. Amanda J. Russell
(Address) 839 N. 34th St.

15 Filed OCT 26 1920, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25 1920.

17 I HEREBY CERTIFY, That I attended deceased from Oct 4th, 1920, to Oct 25th, 1920, that I last saw h[illegible] alive on Oct 23rd, 1920, and that death occurred, on the date stated above, at 9a. m.

The CAUSE OF DEATH* was as follows:-
Arterial Sclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward Pudgrid, M. D.

Oct 25 1920 (Address) 2432 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Govans Presbyterian Cem.	Oct 27 1920
20 UNDERTAKER Horace Burgee & Son	ADDRESS 3631 Falls Rd

TION is very important. See instructions on back of certificates.

D. 47588

Sm. C. 64-10-H. D. Co. 2100 Blks.

D47588

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3634 Maple Ave ST.: 13 WARD)

2-FULL NAME Betty Lee Groome

(a) RESIDENCE. NO. 3634 Maple Ave ST., 13 WARD.

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE Edmund Doris Groome

6 DATE OF BIRTH (month, day, and year) Mch. 5-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Warren Co. Va.

PARENTS

10 NAME OF FATHER John Shipe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Warren Co Va

12 MAIDEN NAME OF MOTHER Betty Lee Shipe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Warren Co Va

14 Informant Bobby Robert Groome

(Address) 3632 Maple Ave

15 Filed OCT 26 1920. 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 5, 1920, to Oct 25, 1920, that I last saw h[er] alive on Oct 25, 1920, and that death occurred, on the date stated above, at 7.45 A m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency
Mitral regurgitation - Loss of Compensation - contributory

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Mitral regurg.

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Alberton Md.

Did an operation precede death? yes Date of Oct 8-20

Was there an autopsy? No for removal of gall stones

What test confirmed diagnosis? Clinical Consultation & Presumption

(Signed) Vernon F Kelly, M. D.

(Address) 3704 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Oct. 28 1920
20 UNDERTAKER	ADDRESS
Evans Burial Co	3614 Falls Rd

IMPORTANT. See instructions on back of certificates. Exact statements of OCCUPATIONS should state what is very important, so that it may be properly classified.

D.47589 (Imhoff) D.47589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 172

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Imhoff

(Residence in Baltimore: No. 1615 Race St.; 39 yrs., mos. ds.)

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April 29, 1881 (Month) (Day) (Year)

7-AGE, 39 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: St Charwoman
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Frank Ludwitzke

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Minnie Troyer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fredrick J. Imhoff

(Address) 1615 Race St

15- Filed OCT 26 1920, 191... Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 23, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Circumscribed brain cancer

Duration 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Kelly (Coroner.) M. D.

Oct 26 1920 (Address) 1615 Race

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem'y

DATE OF BURIAL, Oct 27, 1920

20-UNDERTAKER W. L. Flynn

ADDRESS 1423 Light St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47590

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47590

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 122 N Lanvale ST.: 17 W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Ellen Proctor

(a) RESIDENCE. No. 122 N Lanvale ST., 11 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Joseph L Proctor

6 DATE OF BIRTH (month, day, and year) Nov 20, 1842

7 AGE	77 Years	11 Months	6 Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Towson Md

PARENTS

10 NAME OF FATHER Stephen Rose Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Christy Hitchcock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Elizabeth Cooney

(Address) 122 N Lanvale St

15 Filed OCT 26 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 - 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 22, 1920, to Oct 25, 1920, that I last saw h.r alive on Oct 25, 1920, and that death occurred, on the date stated above, at 3:20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Sepsis

(duration) yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical only

(Signed) J Ramp R Brunson M. D.

Oct 26 1920 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct 27 1920

20 UNDERTAKER — ADDRESS

W R Brooks Sparks Md

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. If unknown, it may be properly classified. Examine statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047591 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047591

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 2515 W Pratt ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theobald Helbing

(a) RESIDENCE. No. 2515 W. Pratt ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Hermina Helbing

6 DATE OF BIRTH (month, day, and year) March 1 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) — Oil

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER August Helbing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hermina Helbing (Address) 2515 Pratt St

15 Filed OCT 27 1920 19 ROBERT J. KRAUTER Registrar

Asst. Registrar Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1920, to Oct 24, 1920, that I last saw him alive on Oct 23, 1920, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

(duration) 4 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Howard W Jones, M. D.

(Address) 222 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct. 27 1920
20 UNDERTAKER C. W. Dill	ADDRESS 3109 Fredk. Ave.

THION is very important. See instructions on back of certificates.

047592 HEALTH DEPARTMENT—CITY OF BALTIMORE 047592

CERTIFICATE OF DEATH.

1-PLACE OF DEATH, CITY OF BALTIMORE (No. 243 N Poppleton St; ST.: 18 WARD) REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Allen

(Residence in Baltimore: No 243 N Poppleton St St. 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colo

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): W don

6-DATE OF BIRTH: Dont Know, (Month) (Day) 1 (Year)

7-AGE: 53 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Do

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Wm Scott

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: C. Harden

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mazzie Smith

(Address) 243 N Poppleton St

15- Filed OCT 27 1920 ROBERT B KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, ~~autopsy or~~ inquiry.) thereon and from the evidence obtained by said (~~Inquest, autopsy or~~ inquiry.) find that said deceased came to ~~his~~ Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Valvular disease of the Heart a few mos (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know (Duration) yrs. mos. 6 ds.

(Signed) HK Gorsuch (Coroner.) M. D.

10.26., 1920 (Address) 117 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Oct 27, 1920
20-UNDERTAKER	ADDRESS
Brown & Leland	1140 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Stock—6-9-19—H. P. Co.—1000 Bks.

0 47593

HEALTH DEPARTMENT—CITY OF BALTIMORE

0 47593

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 120 N Amity ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lou A. Hall

(a) RESIDENCE. No. 120 N Amity ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col'd

5 Single, Married, Widowed, or Divorced (write the word): Mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Virginia Hall

6 DATE OF BIRTH (month, day, and year): Autumn.

7 AGE: Years 48; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Driver Truck

(b) General nature of industry, business, or establishment in which employed (or employer): Lumber Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Alice Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Virginia Hall

(Address): 120 N Amity St

15 Filed: OCT 27 1920 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 24 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1920, to Oct 24, 1920, that I last saw h alive on Oct 24, 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Laryngeal & Pul-
monary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulm. Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Norwood, M. D.

, 19 (Address) 907 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Oct 27 1920
20 UNDERTAKER	ADDRESS
Brown & Tuckwood	Baltimore

THIS CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0447594

HEALTH DEPARTMENT—CITY OF BALTIMORE

0447594

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST.: 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie O'Brien

(a) RESIDENCE. NO. Philadelphia Pa ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 43 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not Known

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 80 Not Known				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cuppon Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cuppon Ireland

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Balto Md

15 Filed OCT 27 1920 ROBERT F. KRAUTER Registrar

Burial Permit Oct 27

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1920

17 I HEREBY CERTIFY, That I attended deceased from May 1890 to Oct 25th 1920.

that I last saw her alive on Oct 25 1920.

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Cbl (duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Chronic Mania (duration) 43 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Phila Pa

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

Oct 26, 1920 (Address) Mt Hope Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct 27/ 1920
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

TION is very important. See instructions on back of certificates.

at it may be properly classified. Exact statement of OCCUPA-

stated EXACTLY. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

64759 5 HEALTH DEPARTMENT—CITY OF BALTIMORE 64759 5

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Philadelphia Road and 15th St.; 16th WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward R. Burgan

(Residence in Baltimore: No. Philadelphia Road & 15th St.; Life yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widowed

6-DATE OF BIRTH, Sept. 9 (Month) (Day), 1847 (Year)

7-AGE,	If LESS than 1 day,
73 yrs. 1 mos. 16 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Emma Gross

(Address) 1311 N. Rose st

15- Filed OCT 27 1920, 191.. ROBERT F. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1920, to Oct. 25, 1920, that I saw him alive on October 19, 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall Bladder

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Gall Stones

(Duration) 17 yrs. mos. ds.

(Signed) Edwin B. Fenby, M. D.

Oct. 26, 1920. (Address) 1223 N. Caroline st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Oct 28, 1920
20-UNDERTAKER	ADDRESS
Jas. C. Miller	2334 Jefferson st

Important. See instructions on back of certificate. Names of PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very

1647596 HEALTH DEPARTMENT—CITY OF BALTIMORE 1647596

CERTIFICATE OF DEATH. 182

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1217 High St. alley) WARD 5

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Blackwell

(Residence in Baltimore: No. 1217 High St. alley St. 10 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	Col.	Married

6-DATE OF BIRTH, Feb (Month) 23 (Day), 1875 (Year)

7-AGE, 25 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country). N. C.

PARENTS.

10-NAME OF FATHER, John Blackwell

11-BIRTHPLACE OF FATHER (State or Country). N. C.

12-MAIDEN NAME OF MOTHER Annie Green

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Blackwell

(Address) 719 N. Center ave.

15- Filed OCT 27 1920, 191... ROBERT P. KRAUTER Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stomach Leg

Foot Hip (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] (Coroner) M. D.

, 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel cemetery	Oct 27, 1920
20-UNDERTAKER	ADDRESS
R. C. Gross	1405 McElderry St

important. See instructions on back of certificate.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec. 6-9-19—H. P. Co.—1000 Blks.

L47597

HEALTH DEPARTMENT—CITY OF BALTIMORE

L47597

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD) 23

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle a. Joyce

(a) RESIDENCE. NO. 134 W. Randall ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 9 mos. 11 ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 25-1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER William Joyce

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md

12 MAIDEN NAME OF MOTHER Ella Clardy

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs Joyce
(Address) 134 W Randall St

15 OCT 27 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/26/20

17 I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1920, to Oct 26, 1920
that I last saw her alive on Oct 26, 1920
and that death occurred, on the date stated above, at 10:50a m.
The CAUSE OF DEATH* was as follows:

Laryngeal diptheria

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) B. MacSwain, M. D.

Oct 27 1920 Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Oct 27/1920
20 UNDERTAKER	ADDRESS
John J Jahey Sons	131 [illegible] St

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D47598 HEALTH DEPARTMENT—CITY OF BALTIMORE D47598

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. New City Hospital ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Richel

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 1yr yrs. mos. ds. How long in U. S., if of foreign birth? 1yr yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	88			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records.
(Address) New City Hospital.

15 Filed OCT 27 1920 19 ROBERT P. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25, 1920

17 I HEREBY CERTIFY, That I attended deceased from December 24, 1918, to October 25, 1920, that I last saw her alive on October 25, 1920, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
(no cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No especial test.

(Signed) [redacted], M. D.

10/26/ 20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Brooklyn	Oct 28-1920
20 UNDERTAKER William Cook	ADDRESS 502 E. Balt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D47599

Coppage 28 2303 N Calvert

REGISTERED No. 47599

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1748 E. North Ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Marie Wohlwa

(a) RESIDENCE. No. 1748 E. North Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ernest Wohlwa

6 DATE OF BIRTH (month, day, and year): Oct 25 1897

7 AGE: Years 23 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): " "

12 MAIDEN NAME OF MOTHER: " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: Ernest Wohlwa (Address) 1748 ~~Eutaw Pl~~ E. North Ave

15 Filed OCT 27 1920 19.. (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1919, to Oct 25, 1920 that I last saw h[illegible] alive on Oct 25, 1920, and that death occurred, on the date stated above, at 5.30 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) 1 yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Tuberculosis Peritonitis (duration) 1 yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) W. G. Coppage, M. D.

, 19 (Address) 2303 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Hill — DATE OF BURIAL: Oct 19

20 UNDERTAKER: H. Cook ADDRESS: Ave & Mo

THION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Eskridge

HEALTH DEPARTMENT—CITY OF BALTIMORE

047600 047600

CERTIFICATE OF DEATH.

129

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1437 N. Central Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna M. Eskridge

(Residence in Baltimore: No. 1437 N. Central Ave St.; 9yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct. 17 (Month), 1882 (Day) (Year)

7-AGE, 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore.

PARENTS.

10-NAME OF FATHER, Conrad Block

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dont Know.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. M. Eskridge

(Address) 1437 N. Central Ave.

15- Filed OCT 27 1920, 191... ROBERT F. KRAUTER Registrar.

Burial Permit Issued

(over)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 19 1920, to Oct 25 1920, that I saw h.. alive on Oct 25 1920, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation—
Severe Anaemia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hemorrhage from uterus

Retained (Duration) yrs. mos. 5 ds.

(Signed) J. Roberts M. D.

10-26., 1920 (Address) 45 E. 22nd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cemetery. DATE OF BURIAL, Oct. 28., 1920

20-UNDERTAKER Robt F. Turner & Son ADDRESS 1442 N. Broadway

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very ... may be properly classified. ... PHYSICIANS should state ...

Spec.—6-9-19—H. P. Co.—1000 Blks.

1047601 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047601

CERTIFICATE OF DEATH. 91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 N. Clinton ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Mayer Dunnigan

(a) RESIDENCE. No. 1531 N. Clinton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 4, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Dunnigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Frances Weaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant William Dunnigan
(Address) 1531 N. Clinton St.

15 Filed OCT 27 1920 ROBERT J. KRAFFT Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 25 1920, to Oct 25 1920, that I last saw him alive on Oct 25 1920, and that death occurred, on the date stated above, at 7.40 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Not

What test confirmed diagnosis? —

(Signed) — [illegible], M. D.

10-27-20 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Oct 27 1920
20 UNDERTAKER	ADDRESS
H. Vander & Son	1710 Flint St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

2047602 HEALTH DEPARTMENT—CITY OF BALTIMORE 662047602

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 Ensor ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Finck

(a) RESIDENCE. NO. 1126 Ensor ST., 10 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., If of foreign birth? 66 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~ of) Mrs Dora A. Finck

6 DATE OF BIRTH (month, day, and year) Jan. 19 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Finck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Frase

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Dora A. Finck

(Address) 1126 Ensor St

15 Filed OCT 27 1920 ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1920

17 I HEREBY CERTIFY That I attended deceased from Sept 28th, 1920, to Oct 27th 1920.

that I last saw h live on Oct 26th 1920.

and that death occurred, on the date stated above, at 3:45 A. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Cerebral)

(duration) yrs. 1 mos. 30 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct. 30 1920
20 UNDERTAKER Henry Storck & Son	ADDRESS 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1047603 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047603

CERTIFICATE OF DEATH.

104

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1134 W. Randall St.; 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George R Joyce

(Residence in Baltimore: No. 1334 W. Randall St.; ....yrs.,....mos.....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, April (Month) 16 (Day), 1920 (Year)

7-AGE, ...yrs. 6 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, William Joyce

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Ella Hardy

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Joyce

(Address) 1334 W Randall St

15-

Filed OCT 27 1920, 191.... ROBERT B KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 26 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 15 1920, to Oct 26 1920, that I saw him alive on Oct 26 1920, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Incontinence

(Duration) ....yrs. 4 mos. ....ds.

(Signed) J. F. Hayden M. D.

10/27/, 1920 (Address) 1 E Randall St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, 10/27, 1920

20-UNDERTAKER J. Haley Lowe — ADDRESS 731 E Eight

Important. See instructions on back of certificate. Names of INFANTS should state whether child, twin, triplet, etc. Exact statement of OCCUPATION is very necessary that it may be properly classified.

Dunn.

Spec.—8-24-14—M. & T.—2000 Bks.

D47604

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47604

CERTIFICATE OF DEATH.

109

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 Homestead St. ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Patrick Dunn

(Residence in Baltimore: No. 807 Homestead St ST.; 15 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: March 25th, 1871. (Month) (Day) (Year)

7-AGE: 39 yrs. 7 mos. 0 ds. If LESS than 1 day, ...hrs. or .....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Coleor M.
(b) General nature of industry, business, or establishment in which employed (or employer): C. A. A.

9-BIRTHPLACE, (State or Country): Connecticut.

PARENTS.

10-NAME OF FATHER: James P. Dunn Jr.

11-BIRTHPLACE OF FATHER (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Catherine Avens

13-BIRTHPLACE OF MOTHER (State or Country): Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Dunn

(Address) 807 Homestead St.

15-OCT 27 1920 ROBERT B KRAUTER

Filed....., 191..... Registrar

Burial Permit Issued by Health Officer

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: October 25th, 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13th 1920, to Oct 25th 1920, that I saw h.. alive on Oct 25th 1920 and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows: Cerebral Embolism

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary): Chronic Arthritis

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) Geo. Morgan Moore M. D.

Oct. 25th, 1920 (Address) 1915 E. 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: 10/28..., 1920

20-UNDERTAKER: George J. Pulls — ADDRESS: 1735 Harford Ave.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

047608 HEALTH DEPARTMENT—CITY OF BALTIMORE 047605

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 N Duncan ST.; 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Polesny

(Residence in Baltimore: No. 923 Duncan St.; 4 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... Jan (Month) ..... 1 (Day) ..... (Year)

7-AGE, ... 77 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Vaclav Polesny

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Ant Kroun

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Johanna Polesny

(Address) ..... 923 N Duncan St

15- Filed OCT 27 1920, 191..... ROBERT B KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 26 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 191..., to Oct 26 1920, that I saw h[illegible] alive on Oct 26 1920, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Uremia Hypertension

Chronic Glomerulo Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Edema of Lung

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) ..... M.D.

(Address) 2007 Baltimore MD

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Hill

DATE OF BURIAL, Oct 28, 1920

20-UNDERTAKER Frank Brack Son

ADDRESS 1706 Eastern Ave

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.47606 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.47606

CERTIFICATE OF DEATH. 138

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore Gen Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vietta Mae Thomas.

(a) RESIDENCE. No. 1024 Warner St. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry W Thomas,

6 DATE OF BIRTH (month, day, and year) May 13, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home. 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Pa.

PARENTS

10 NAME OF FATHER Ulysses S. Allison

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Penna.

12 MAIDEN NAME OF MOTHER Alice Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ~~York~~ ~~Md~~ Penna

14 Informant Harry W. Thomas (Address) 1523 Bower St.

15 Filed OCT 27 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1920, to Oct. 26, 1920.
that I last saw her alive on Oct 26, 1920.
and that death occurred, on the date stated above, at 2.50 a. m.
The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

(duration) yrs. mos. 35 ds.

CONTRIBUTORY (Secondary) Pyelitis Surgical Shock
Caesarian Section
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1024 Warner St

Did an operation precede death? Yes Date of 10-25-20

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) Howard Tolson, M. D.

19 (Address) 1213 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
York Pa.	Oct. 28 192
20 UNDERTAKER	ADDRESS
John Mitchell	120 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

GE should be properly classified. Exact statement of OCCUPA-

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.47607

D.47607

HEALTH DEPARTMENT—CITY OF BALTIMORE

STILLBIRTH No. 1

CERTIFICATE OF DEATH.

151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto. Gen'l Hosp. St. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Thomas

(a) RESIDENCE. No. 1024 Warney ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word)

3A If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 25, 1920

7 AGE — Years: — Months: 0 — Days: 0 — If LESS than 1 day, ... hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto., Md

PARENTS

10 NAME OF FATHER Harry W. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Nellie M. Allison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Pa.

14 Informant Harry W. Thomas
(Address) 1523 Druid Pk

15 Filed OCT 27 1920, 19 Robert F. Harrison,
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-25 1920

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...,
that I last saw her alive on 10-25, 1920,
and that death occurred, on the date stated above, at 7:30 p.m.
The CAUSE OF DEATH* was as follows:

Premature Delivery
(5 months)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal Eclampsia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard J. Tolson, M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: York Pa — DATE OF BURIAL: Oct 28 1920

20 UNDERTAKER: John Ostrichell — ADDRESS: 1201 W. Fayette St

TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D.47608 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47608

28

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 S Wanford ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kaszak

(a) RESIDENCE. NO. 817 S Wanford Ave ST. 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of married

6 DATE OF BIRTH (month, day, and year) Nov. 1-1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	11	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machine Operator
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer Balto Copper Works

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Kaszak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Kujawa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Michael Pruchniewski
(Address) 817 S Wanford Ave

OCT 27 1920 19 Robert T. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 26 1920

17 I HEREBY CERTIFY, That I attended deceased from October 26 - 1920, to October - 26 - 1920, that I last saw h— alive on October 26 1920, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis —

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Septic Infection

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? City —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? yes

(Signed) Jno A Brannan, M. D.

, 19 (Address) 125 S Broadway —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Oct 28 1920
20 UNDERTAKER Stephen J Fialkowski	ADDRESS Woodlawn Md

TION is very important. See instructions on back of certificates.

Lyler Lyler

Spec. 6-9-19—H. P. Co.—1000 Bks.

D. 47609 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 47609

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Lyler

(a) RESIDENCE. No. 939 Mason St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Jessie Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Lucy Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records (Address) M.T.H.

15 Filed OCT 27 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1920, to Oct. 25, 1920, that I last saw h[illegible] alive on Oct. 25, 1920, and that death occurred, on the date stated above, at 11.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. J. Bayley, M. D.

10-25-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cmty	Oct 28 1920
20 UNDERTAKER	ADDRESS
George H. Holland	1631 E. H. Ave

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.47610 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47610

29

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. University Hospital ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Duncan Smith

(Residence in Baltimore: No. 1730 Bayard St. St.; 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. B

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Oct 25 (?), 1890 (Month) (Day) (Year)

7-AGE, 30 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). N. C.

PARENTS.

10-NAME OF FATHER. Wm. Henry Smith

11-BIRTHPLACE OF FATHER (State or Country). N. C.

12-MAIDEN NAME OF MOTHER Laura McNeil

13-BIRTHPLACE OF MOTHER (State or Country). N C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Olivia Whitaker

(Address) 1730 Bayard St

15- OCT 27 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 25, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1920, to Oct 25 1920, that I saw h[e] alive on Oct 25 1920, and that death occurred, on the date stated above, at 1.30 p m.

The CAUSE OF DEATH* was as follows: Acute miliary Tuberculosis

with Tuberculous meningitis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Pneumonia

(Duration) 6 yrs. mos. 1 ds.

(Signed) W. T. Gayer M. D.

Oct 25, 1920 (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 8 ds. In the State 3 yrs. mos. ds.

Where was disease contracted, if not at place of death? urban

Former or usual residence 1730 Bayard St

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Oct 28 1920

20-UNDERTAKER Brown & Cleland ADDRESS 114 N. Schroeder

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 47611

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 47611

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 S Payson St ST. 70 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Galyee

(Residence in Baltimore: No. 515 S Payson St St.; 46 yrs., 8 mos. 7 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Wid'd

6-DATE OF BIRTH, Feb ....., 1873
(Month) (Day) (Year)

7-AGE, 46 yrs. 8 mos. ..... da.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Sales Lady
(b) General nature of industry, business, or establishment in which employed (or employer)..... Stewart & Co

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, John Galyee

11-BIRTHPLACE OF FATHER (State or Country), city

12-MAIDEN NAME OF MOTHER Amelia Blunt

13-BIRTHPLACE OF MOTHER (State or Country), city

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mary Davis

(Address)..... 2718 Evergreen Ave

15- Robert P. Harrison,
Registrar.
Burial Permit Clerk.

OCT 27 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 25th 1920, to Oct 26th 1920, that I saw her alive on Oct 25th 1920, and that death occurred, on the date stated above, at 6.45 Am.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 1 mos. ..... da.

CONTRIBUTORY (Secondary)

(Duration) yrs. ..... mos. ..... da.

(Signed) H. S. Hamrick M. D.

Oct 27, 1920. (Address) 1929 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? 869 N. Franklin St

Former or usual residence 869 N. Franklin St

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct 28, 191.

20-UNDERTAKER W. J. Eichhorn & Son — ADDRESS Baltimore

IMPORTANT. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47612

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47612

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 839 W North Ave (St.) (Ward) 14

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles L — Holston

(a) RESIDENCE. No. 839 W North Ave St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie M Holston

6 DATE OF BIRTH (month, day, and year) July 22 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Lyceum Runnels Foshell

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John H Holston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Whitman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Arthur F. Holston
(Address)

OCT 27 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27th 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 22nd, 1920, to Oct 27th, 1920

that I last saw h... alive on Oct 26th, 1920

and that death occurred, on the date stated above, at 3 a. m.,

The CAUSE OF DEATH* was as follows:

Left Hemiplegia

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam

(Signed) Eugene Douglas M. D.

, 19 (Address) 830 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Ridge Cem

DATE OF BURIAL Oct 29 1920

UNDERTAKER W J Luckner & Son

ADDRESS Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact st... of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

D.47613

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47613

CERTIFICATE OF DEATH.

92-010

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 54 East Ave ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen A. Deal

(Residence in Baltimore: No. 54 East Ave St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug (Month) 1 (Day), 1876 (Year)

7-AGE, 44 yrs. 2 mos. 24 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Pt. Engraver
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Geo T Deal

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth Williams

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Martha Eccleston

(Address) 54 E Ave

15- OCT 27 1920 191.... Robert P. Harrison, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 25 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1920, to Oct 25 1920, that I saw h[e] alive on Oct 25 1920, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

1 Pneumonitis

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Fer Graphs

(Duration) ....yrs. ....mos. 10 ds.

(Signed) W. T. Perry M. D.

Oct 26 20, 191.. (Address) 622 W. Mulberry Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Oct 28, 1920

20-UNDERTAKER E LeRoy Shiffler — ADDRESS 124 E Mulberry

...on back of certificate.

D47614 HEALTH DEPARTMENT—CITY OF BALTIMORE 2047614

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Union Protestant Infirmary WARD) 475-001 REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Antonio

(Residence in Baltimore: No. 2307 Pennsylvania Ave, St. 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, Aug 7 (Month) (Day) 1907 (Year)

7-AGE, 13 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Salvatore Antonio

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Salvadore Flesp

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Salvatore Antonio

(Address) 2307 Penna ave

15- Filed OCT 28 1920, 191 ROBERT B KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 24, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull
extended accident,
(Duration) 10 minutes yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. D. Hennessy M. D. (Coroner.)

Oct. 27, 1920 (Address) 2502 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Penna Ave. & Baker.

Former or usual residence 2307 Pennsylvania Ave

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Oct 28, 1920

20-UNDERTAKER Daniel Easton — ADDRESS 916 Penn ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D47645 HEALTH DEPARTMENT—CITY OF BALTIMORE D47615

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Dolphin & Myrtle Ave. 17 WARD) REGISTERED No. C 17

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Akins

(Residence in Baltimore: No. 1141 Myrtle Ave St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, ~ (Month) (Day) 1907 (Year)

7-AGE, 13 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work student
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Anna Gilmore

13-BIRTHPLACE OF MOTHER (State or Country), N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary C. Coleman

(Address) 1141 Myrtle Ave

15- Filed OCT 28 1920, 191... ROBERT B KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 26, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound of head, (probably accidental) (Instantaneous death)

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. A. J. Hennessy M. D. (Coroner.)

Oct. 27, 1920 (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Bur — DATE OF BURIAL, Oct 28 '20

20-UNDERTAKER Daniel Easton — ADDRESS 916 Pa Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D47616 — 120 — D47616

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 W. Saratoga ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham White

(a) RESIDENCE. NO. 824 W. Saratoga ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Norcissa White

6 DATE OF BIRTH (month, day, and year) ——— 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	45	—	———	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Narcissa White (wife)
(Address) 835 Clinton St.

15 Filed OCT 28 1920 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/26 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct, 6, 1920, to Oct, 26, 1920, that I last saw h~~e~~ alive on Oct, 26, 1920, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cerebral Oedema

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis & Arteriosclerosis (duration) ~~one known~~ yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine exam, ot,

(Signed) Dan'l Fraenkel, M. D.

10/26 1920 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn Cemetery	Oct 28 19
20 UNDERTAKER John R. Pondrin	ADDRESS 1424 W. Pratt St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D47617 HEALTH DEPARTMENT—CITY OF BALTIMORE 91 D47617

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 W. Preston ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther Naomi Thomas

(Residence in Baltimore: No. 506 W Preston St.; 1 yrs., 2 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, July 29, 1919 (Month) (Day) (Year)

7-AGE, 1 yrs. 2 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Walter Thomas

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Florence Fooks

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Thomas

(Address) 506 W. Preston St

15- OCT 28 1920 ROBERT B KRAUTER

Filed ....., 191.... Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26th, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 19th 1920, to Oct 26th 1920, that I saw h e alive on Oct 26th 1920, and that death occurred, on the date stated above, at 7P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ... yrs. ... mos. 9 ds.

CONTRIBUTORY (Secondary) None Known

(Duration) ... yrs. ... mos. ... ds.

(Signed) Chas. L. Keller M. D.

Oct 27th, 1920. (Address) 2426 W. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Benedick. Chas Co. md | DATE OF BURIAL, Oct 28, 1920

20-UNDERTAKER John H. Toadvine ADDRESS 142 Hazel St

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

D47618 HEALTH DEPARTMENT—CITY OF BALTIMORE D47618

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp ST.: 16 WARD) 79 REGISTERED No. C

2-FULL NAME Ruth Steward

(Residence in Baltimore: No. Clayton Md - St.: 15 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fmar

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 46 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) 837

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Daniel Hurlon

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER Julia Carew

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev Thos J Murphy

(Address) Mercy Hospital

15- Filed OCT 28 1920, 191.... ROBERT B KRAUTER Registrar.
Burial Permit issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv dis Heart

Dur Rheu (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

10/28, 1920 (Address) 1659 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 618 Bruce St

19-PLACE OF BURIAL OR REMOVAL, Laurel County — DATE OF BURIAL, 10/27, 1920

20-UNDERTAKER W E Cox & P Co — ADDRESS 102 E Eden St

IMPORTANT. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47619

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47619

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bridle & Pellman Sanatorium

REGISTERED NO. 1720

CITY OF BALTIMORE: (No. 2714 N. Charles ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Swan Dunlap

(a) RESIDENCE. NO. 2714 N. Calvert ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred About 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About	73	--	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Dunlap

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eliza Swan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant H. W. Mears & Son's Records

(Address) 805 N. Calvert Street

15 FILED OCT 28 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1920, to Oct 26, 1920, that I last saw h[er] alive on Oct. 25, 1920, and that death occurred, on the date stated above, at 8.45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vernon H. Carden, M. D.

10/26/1920 (Address) 750 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery

DATE OF BURIAL: 10/28, 1920

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 N. Calvert

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

947620

HEALTH DEPARTMENT—CITY OF BALTIMORE

81 947620

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 113 Dorchester Alley St. 27 WARD)

2-FULL NAME Mary A. Brown

(a) RESIDENCE. No. 113 Dorchester Alley St. 27 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis E. Brown

6 DATE OF BIRTH (month, day, and year) Aug 19, 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
84	84	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto County Md.

PARENTS

10 NAME OF FATHER Geo Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ruth Stubbins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. A. Carlton
(Address) 304 E. Maryland Ave

15 Filed OCT 28 1920 ROBERT B. [illegible]
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 16th, 1920, to Oct. 26, 1920, that I last saw h[illegible] alive on Oct. 26th, 1920, and that death occurred, on the date stated above, at 10.5 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congestion of Edema Brain
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clynical

(Signed) Albertus Carlton, M. D.

Oct 28 1920 (Address) 1303 Mad. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge C | DATE OF BURIAL: Oct 28 1920

20 UNDERTAKER: W. M. Faulkner | ADDRESS: 1224 Mt Royal Ave

TION is very important. See instructions on back of certificates. it may be properly classified. Exact statement of OCCU

D47621 HEALTH DEPARTMENT—CITY OF BALTIMORE D47621

CERTIFICATE OF DEATH.

REGISTERED No. C 170

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1401 Nicholson St. St. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Hulse

(Residence in Baltimore: No. 1401 Nicholson St. St.) 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White,	Married

6-DATE OF BIRTH, September 28th. 1864, 1
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
56 yrs. mos. 27 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), New Jersey

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Meta Hulse.(wife)

(Address) 1401 Nicholson St.

15- Filed OCT 28 1920, 191.... ROBERT B KRAUTER Registrar.

Burial Permit Giert

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 25th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Eisenhardt (Coroner) M. D.

Oct 26th, 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, Oct 28 1920

20-UNDERTAKER H. Sander Son ADDRESS 1126 Fleet

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47622 HEALTH DEPARTMENT—CITY OF BALTIMORE D47622

CERTIFICATE OF DEATH.

REGISTERED NO. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 N. Lakewood Ave ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. McKeever

(a) RESIDENCE. NO. 113 N. Lakewood Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 2, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	10	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Iron Moulder
(b) General nature of Industry, business, or establishment in which employed (or employer) D47
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Maryland

PARENTS

10 NAME OF FATHER Bernhard L. McKeever

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Schaeffler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ga.

14 Informant George H. Sommer
(Address) 113 N. Lakewood Ave

15 Filed OCT 28 1920, 19.... ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1920

17 I HEREBY CERTIFY, That I attended deceased from June 11 1920, to Oct 25 1920, that I last saw h[illegible] alive on Oct 25 1920, and that death occurred, on the date stated above, at 11.20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Tuberculosis

(duration) yrs. 4 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Mo T. B.

(Signed) Edmund Rutherford, M. D.

Oct 27 1920 (Address) 2432 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem. DATE OF BURIAL: Oct 28 1920

20 UNDERTAKER: H. Sander & Sons ADDRESS: 1210 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement as to OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47623 HEALTH DEPARTMENT—CITY OF BALTIMORE. D47623

CERTIFICATE OF DEATH. 176

1-PLACE OF DEATH Mercy Hospital REGISTERED NO. 8676

CITY OF BALTIMORE. No. Calvert St. ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick F Courtice

(a) RESIDENCE. No. 539 S Paca ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lucy Courtice

6 DATE OF BIRTH (month, day, and year): Oct 20, 1834

7 AGE — Years: 86 — Months: — — Days: 7 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Trade Print Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: John Courtice

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Lucy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): Mrs Eva Tessaro

15 Filed OCT 28 1920 19 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 27, 1920

17 I HEREBY CERTIFY, That I attended deceased from October 12, 1920, to Oct 27, 1920, that I last saw him alive on Oct 27, 1920, and that death occurred, on the date stated above, at 4 40 p m.

The CAUSE OF DEATH* was as follows:

Prostatic Hypertrophy

Bright's (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) D J Dessaro M. D

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Oct 30 1920

20 UNDERTAKER: W G Gutmeyer & Co — ADDRESS: Baltimore

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

947624

HEALTH DEPARTMENT—CITY OF BALTIMORE

947624

CERTIFICATE OF DEATH.

68

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 727 Glenwood Ave St.; 27 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard M Strain

(Residence in Baltimore: No. 727 Glenwood Ave Forrons St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Oct 31, 1874 (Month) (Day) (Year)

7-AGE, 46 yrs. 9 mos. 26 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Maryville Mo

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah T. Strain

(Address) 727 Glenwood Ave Forrons

15-

Filed....., 191.....

ROBERT B KRAUTER

OCT 28 1920

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26 (26), 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 3 1920, to Oct 26 1920, that I saw him alive on Oct 26 1920, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

General break down

Brought about by Insanity

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Insanity

(Duration) yrs. 5 mos. ds.

(Signed) E. M. Duncan M. D.

Oct 28, 1920 (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	Oct 29, 1920
20-UNDERTAKER	ADDRESS
Wm J. Hartwell	2230 W. Baltimore St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D47625- HEALTH DEPARTMENT—CITY OF BALTIMORE D47625-

CERTIFICATE OF DEATH.

79-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 Bruce ST.; 17 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachael Lewis

(Residence in Baltimore: No. 718 Bruce St.; 70 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.)
F.	W.	Widowed

6-DATE OF BIRTH, Feb. (Month) 12 (Day), 1860 (Year)

7-AGE,	If LESS than 1 day,
60 yrs. 8 mos. 15 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nelson Lewis

(Address) 718 Bruce St

15-

Filed OCT 28 1920, 191.....

ROBERT B KRAUTER
Burial Permit
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 27 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 25 1920, to Oct 27 1920, that I saw h- alive on Oct 27 1920, and that death occurred, on the date stated above, at 5 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Broncho Pneumonia

..... (Duration)...5... yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration).....yrs.....mos. 3 ds.

(Signed) Edw. McCoolaw M. D.

Oct 28, 1920. (Address) 24 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	10/29, 1920
20-UNDERTAKER	ADDRESS
Geo. A. Farley Sons	Fulton & Fayette

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bku.

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very ... properly classified. ... may be given in state

D47626

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47626

CERTIFICATE OF DEATH.

U.D.J. #1

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST.; 70 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs John E. Lane (Laura) V.

(Residence in Baltimore: No. 1909 Wilkins Ave St.; 61 yrs. 11 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, November 17, 1858 (Month) (Day) (Year)

7-AGE, 61 yrs. 11 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Mr. John Collins

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Margaret Trumbo

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Lane

(Address) 1909 Wilkins Ave

15-

Filed OCT 28 1920 ROBERT A KRAUTER

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 26, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 17 1920, to Oct 26 1920, that I saw her alive on August 26 1920, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Carcinomatosis of Abdominal Wall Primary in the Colon

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Abscess of Abdominal Wall

(Duration) yrs. 3 mos. 9 ds.

(Signed) A. H. Jameson M. D.

Oct. 26, 1920 (Address) Union Memorial Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 2 mos. 9 ds. In the State 61 yrs. 11 mos. 8 ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence 1909 Wilkins Ave City

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, 10/28, 1920

20-UNDERTAKER Geo. A. Finley Fulton & Fayette ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

047627

HEALTH DEPARTMENT—CITY OF BALTIMORE

047627

105

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 Linden Ave ; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Jackson Young.

(Residence in Baltimore: No. 1208 Linden Ave St.; 44 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, WIDOWED, ~~OR DIVORCED~~, (*Write* the word.) Widowed

6-DATE OF BIRTH, July (Month) 23 (Day), 1837 (Year)

7-AGE, 83 yrs. 3 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Capt. Wm Scott Young.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md

12-MAIDEN NAME OF MOTHER Mary Dutton

13-BIRTHPLACE OF MOTHER (State or Country), Halford Co, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eldridge H. Young.

(Address) 1208 Linden Ave

15-

Filed OCT 28 1920, 191.....

ROBERT B. KRAUTER

BUREAU OF VITAL STATISTICS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 27 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 3d 1919, to Oct. 27th 1920, that I saw him alive on Oct. 26th 1920, and that death occurred, on the date stated above, at 9.10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Catarrhal Enteritis

(Duration) 1 yrs. 8 mos. 24 ds.

CONTRIBUTORY (Secondary).....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edw. H. Cummings M. D.

Oct. 27th, 1920 (Address) 539 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem	Oct. 29., 1920
20-UNDERTAKER John C. Mitchell	ADDRESS 1701 W. Fayette

Important. See instructions on back of certificate. ...it may be properly classified. Exact statement of OCCUPATION is very

D47628 HEALTH DEPARTMENT—CITY OF BALTIMORE D47628

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1508 Pennsylvania St. 16 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph John Frazier

(Residence in Baltimore: No. 1014 Bruce St. 53 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May 5, 1867 (Month) (Day) (Year)

7-AGE, 53 yrs. 5 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): (General)

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Henry Frazier

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ann Frazier

(Address) 1019 Bruce St.

15-

OCT 28 1920 ROBERT P. HARLAN

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 24, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

5 min Hrs.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. L. D. Hennessey M. D. (Coroner.)

Oct. 25, 1920 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetary — DATE OF BURIAL, Oct 28, 1920

20-UNDERTAKER Clement Hall 1945 — ADDRESS Penna Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state carefully supplied. AGE of infants, NAME of disease, and OCCUPATION of every important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

947629

HEALTH DEPARTMENT—CITY OF BALTIMORE

947629

CERTIFICATE OF DEATH.

103

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 W. Bruce ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Naylor.

(a) RESIDENCE. No. 235 W. Bruce ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. 1 mos. 26 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Naylor.

6 DATE OF BIRTH (month, day, and year) Aug 29, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) Construction Employer

(c) Name of employer Charles Burdette

9 BIRTHPLACE (city or town) (State or country) A A Co., Md.

PARENTS

10 NAME OF FATHER Benjamin Naylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown Oct 26, 1920

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Frank T. Butler
(Address) 231 W. Bruce St.

15 Filed ..., 19.. Registrar

OCT 28 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1920, to Oct 25, 1920, that I last saw h— alive on Oct 25, 1920, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows: over

Acute Gastritis 2d Obt Colon

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Gastritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 235 W. Bruce.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Diagnosis

(Signed) William H. Wright, M. D.

(Address) 1209 Premium

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Oct 29 1920
20 UNDERTAKER	ADDRESS
Clement Hall	1945 Penna ave

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not T.B. no other history

Spec.—8-24-14—M. & T.—2000 Bks.

Infy of Walter & Emma Ophus

047630

HEALTH DEPARTMENT—CITY OF BALTIMORE

047630

CERTIFICATE OF DEATH.

REGISTERED No. C 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 534 N. Eden St ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kid.

(Residence in Baltimore: No. 534 N. Eden St St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Col.	Single

6-DATE OF BIRTH, Oct. (Month) 26. (Day) 1920 (Year)

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 7 hrs. ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Kid
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, Walter Ophus

11-BIRTHPLACE OF FATHER (State or Country), Dorchester Co, Md

12-MAIDEN NAME OF MOTHER Anna Smith

13-BIRTHPLACE OF MOTHER (State or Country), Lancaster Co, Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Smith

(Address) 534 N. Eden St

15- OCT 28 1920 ROBERT E KRAUTER Registrar.

Filed ..... 191.. .....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 26, (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased ~~from~~ 26/10/1920, to ~~191~~, that I saw him alive on 26/10/1920, and that death occurred, on the date stated above at 7 p. m.

The CAUSE OF DEATH* was as follows:

Deficient Vitality.

a few hours

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. Mayfield Davis M. D.

27/10/1920 (Address) 427 N. Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Zion Cemetary	Oct 28, 1920
20-UNDERTAKER	**ADDRESS**
R. L. Gross	1405 McElderry St

Important. See instructions on back of certificate. ... may be properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47631 HEALTH DEPARTMENT—CITY OF BALTIMORE D47631

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 Prestman ST.; 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Thompson

(a) RESIDENCE. No. 1518 Prestman ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? • yrs. 15 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 1919

7 AGE: Years — Months 1 Days 3 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Joseph E Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sarah E Bands

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Sarah E Bands
(Address) 1518 Prestman

15 Filed OCT 28 1920 ROBERT F [illegible]
Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/26/20

17 I HEREBY CERTIFY, That I attended deceased from 10/21/20 19.... to 10/26/20 19....
that I last saw her alive on 10/25/20
and that death occurred, on the date stated above, at 5:55a m.
The CAUSE OF DEATH* was as follows:

Bronchitis

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? 1518 Prestman St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) W R Blaylock, M. D.

, 19 (Address) 1380 N Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St peters — DATE OF BURIAL: Oct 28 19

20 UNDERTAKER: JAMES H. DENNIS
ADDRESS 1303 PRESTMAN ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47632

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 D 47632

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2498 ½ Ft ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Kall

(a) RESIDENCE. NO. 2498 ½ ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Kall

6 DATE OF BIRTH (month, day, and year): May 24 1844

7 AGE: Years 36 Months 5 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thomas Gunther

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Kate Fritzgen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Charles Kall
(Address) 2493 S. 7th St

15 Filed 10/28, 19 20 ROBERT E. KRAUTER Registrar

OCT 28 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 28 19

17 I HEREBY CERTIFY, That I attended deceased from 10/25/20, 19, to 10/28/20, 19, that I last saw h[illegible] alive on 10/27/20, 19, and that death occurred, on the date stated above, at 12 10 m.

The CAUSE OF DEATH* was as follows:

Pthisis Pulmonalis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): D. B. Laryngitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) Dudley Morris, M. D.

(Address) 701 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemt	Oct 30 1920

20 UNDERTAKER: Peter Bigane Back — ADDRESS: 502 E Balto

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47633 HEALTH DEPARTMENT—CITY OF BALTIMORE D47633

CERTIFICATE OF DEATH. X 150

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cordelia Dearman

(a) RESIDENCE. NO. Ward Alabama ST., WARD. Ward Alabama
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER Andrew Dearman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Ruth Reaves

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Hospital Records
(Address)

15 Filed OCT 20 1920, 19 ROBERT B KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1920, to Oct 22, 1920, that I last saw her alive on Oct 22, 1920, and that death occurred, on the date stated above, at 11:40 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Hydrocephalus (Operation)

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Davison, M. D.

, 19 (Address) J H H Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cuba Ala	10/28 1920

20 UNDERTAKER Jack Lewis ADDRESS 1411 E Baltd St

TION is very important. See instructions on back of certificates.

D47634 HEALTH DEPARTMENT—CITY OF BALTIMORE D47634

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin Sq Hospital ST.: 18 172 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E Lupton Jr

(Residence in Baltimore: No. 1042 Hollins St.: yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	Single

6-DATE OF BIRTH, Aug (Month) 22 (Day), 1919 (Year)

7-AGE, 1 yrs. 2 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Balto City,

PARENTS.

10-NAME OF FATHER, James E Lupton

11-BIRTHPLACE OF FATHER (State or Country) Balto md

12-MAIDEN NAME OF MOTHER Annie Mitzel

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward E Lupton

(Address) 1042 Hollins St

15-

Filed OCT 28 1920, 191.....

ROBERT F KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 26 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull from Fall from Window Accident

(Duration) .....yrs. .....mos. 20 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) James M Fenton (Coroner.) M. D.

Oct 26 1920 (Address) Tow Chas St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .....yrs. .....mos. 20 ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? 1042 Hollins St

Former or usual residence 1042 Hollins St

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Oct 28th, 1920

20-UNDERTAKER Joseph B. Cook — ADDRESS 1003 W. Balto St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047635 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047635

CERTIFICATE OF DEATH.

H1

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 428 S. Stricker St. ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lyston

(a) RESIDENCE. No. 428 S. Stricker St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Lyston

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired, Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) at B and O.R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Lyston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Tierney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. J.M.Faherty

(Address) 428 S. Stricker St.

15 Filed OCT 28 1920 ROBERT E KRAUTER Registrar

Burial Permit Oleyb

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27th 19 20

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1920, to Oct 27, 1920, that I last saw him alive on Oct 26, 1920, and that death occurred, on the date stated above, at 9.45 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Intestines

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) M. A. O'Neill, M. D.

10/27 1920 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Oct 30 19 20
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W Baltimore

TION is very important. See instructions on back of certificates.

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

93

2047636 HEALTH DEPARTMENT—CITY OF BALTIMORE 2047636

CERTIFICATE OF DEATH.

REGISTERED No. C 24 79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1805 Jackson Street. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert R. Sturgeon.

(Residence in Baltimore: No. 1805 Jackson Street.

8 -- 8 -- 16.
St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Single.

6-DATE OF BIRTH, February 9th, 1912., 1
(Month) (Day) (Year)

7-AGE, 8 yrs. 8 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, James A. Sturgeon.

11-BIRTHPLACE OF FATHER (State or Country), England.

12-MAIDEN NAME OF MOTHER Maggie Brady.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Sturgeon, (mother).

(Address) 1805 Jackson Street.

15-

Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 25th, 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Oct 27th., 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cemetery	Oct. 28., 1920
20-UNDERTAKER	ADDRESS
E. J. Fanning & Son	1460 Battery Ave.

OCT 28 1920 ROBERT R. HEATHER Registrar of Vital Statistics

IMPORTANT. DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

047637

HEALTH DEPARTMENT—CITY OF BALTIMORE

136 047637

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Lepton ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna B Ragon

(Residence in Baltimore: No. Lepton St Morrell Park St.; ..... yrs.. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, 2 (Month) 12 (Day), 1875 (Year)

7-AGE, 45 yrs. 8 mos. 14 ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Lepton St Morrell Park

PARENTS.

10-NAME OF FATHER, Augustus Schmidt

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ~~Chas~~ John Ragen

(Address) Lepton Morrell Park

15-

Filed OCT 28 1920, 191..... ROBERT F. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 26 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-25 1920, to 10-26 1920, that I saw her alive on 10 26 1920, and that death occurred, on the date stated above, at 6.15 p. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Contributory Pulmonary Tuberculosis

Nephritis (Duration) .....yrs. .....mos. .....ds.

(Signed) Thos B Wyatt M. D.

10-27, 1920 (Address) Lakeside

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Matthias — DATE OF BURIAL, Oct 29, 1920

20-UNDERTAKER Mr & Mrs H S Disch — ADDRESS 2651 Frederick Ave

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very much to be desired. Information required by law; it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Blks.

144030
L947638

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

K 104 L947638

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marjory Pearce

(a) RESIDENCE. No. NE Cor 4th & Van Buren St. Wilmington Delaware WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11-1920

7 AGE — Years — Months: 2 1/2 — Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Delaware

PARENTS

10 NAME OF FATHER: George Pearce

11 BIRTHPLACE OF FATHER (city or town) (State or country): Delaware

12 MAIDEN NAME OF MOTHER: Anna Tuttle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Delaware

14 Informant: Father

(Address)

15 Filed OCT 28 1920 ROBERT E. LAZENBY Registrar

Burial Permit Oct 28

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1920, to Oct 28, 1920,

that I last saw her alive on Oct 28, 1920,

and that death occurred, on the date stated above, at 12 2 m.

The CAUSE OF DEATH* was as follows:

Diarrhea (not Dysentery)

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death? Wilmington, Del

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James C. Fox, Jr., M. D.

Oct 27 1920 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wilmington, Del — DATE OF BURIAL: 10/28 1920

20 UNDERTAKER: J. J. Moran — ADDRESS 3000 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—[illegible]—19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44035 D47639 — X 150 — D47639

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude C Watson

(a) RESIDENCE. No. Virginia Ave Towson, Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 21 1920

7 AGE — Years: — Months: 6 Days: 6 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Wilson Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Estrude Disinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Record
(Address): J. H. H.

15 Filed OCT 28 1920 ROBERT E LAMISTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27th 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 26th, 1920, to Oct 27th, 1920, that I last saw h[illegible] alive on Oct 27th, 1920, and that death occurred, on the date stated above, at 11.40 a. m.

The CAUSE OF DEATH* was as follows:

~~Pneumonia~~

Congenital Hydrocephalus
(Duration)

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY ~~Hydrocephalus~~
(Secondary)

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. E. Davison, M. D.

, 19 (Address) J. H. H. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill Cem. Towson	Oct 28 1920
20 UNDERTAKER	ADDRESS
Jobes Burns Sons	Towson

TION is very important. See instructions on back of certificates.

It may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1009 Bks.

D47640

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D47640

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526-S-15th St. 26 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel Perkins

(a) RESIDENCE. No. 526-S-15th St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Edward Perkins

6 DATE OF BIRTH (month, day, and year) Oct 22 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 027

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER — Slaughter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Lydia Deaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Edward Perkins (Address) 526 S. 15th St

15 Filed OCT 28 1920 ROBERT E. LAMBERT Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 20.

17 I HEREBY CERTIFY, That I attended deceased from Oct 23. 1920. to Oct 26 1920. that I last saw h[e] alive on Oct 26 1920. and that death occurred, on the date stated above, at 8:44 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Was at State Sanatorium for 2 weeks following Aug 16th) (duration) yrs. 6 mos. 19 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? Tests made at State Sana-

What ~~test~~ confirmed diagnosis? Torium

(Signed) Leo Kaufmeky M. D.

Oct 26 1920 (Address) 3035 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakmount Cemetery	10/29/20 1920
20 UNDERTAKER	ADDRESS
L. A. Moan	[illegible] Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1047641 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047641

CERTIFICATE OF DEATH.

42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2729 Dillon ST.; 1 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katie Potter

(Residence in Baltimore: No. 2729 Dillon St. St. 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec 24, 1888
(Month) (Day) (Year)

7-AGE, 31 yrs. 10 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0367

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Peter Kruzla

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Mary Zup.

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Potter

(Address) 2729 Dillon St

15- OCT 28 1920 ROBERT F KRAUTER
Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 23 1920, to Oct 26 1920
that I saw h cr alive on Oct 26 1920
and that death occurred, on the date stated above, at 4.45 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs. ....mos. 10 ds.

(Signed) Fred Karbusky M. D.

Oct 28, 1920 (Address) 2931 O'Donnell

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem

DATE OF BURIAL, Oct. 28, 1920

20-UNDERTAKER Stephen J. Fiatkowski

ADDRESS 1000 N. Lemmon

important. See instructions on back of certificate.

...e properly classified. Exact statement of OCCUPATION is very

D.47642

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47642 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1519 Friendship ST., 15 WARD)

REGISTERED NO. 170

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. McCormick

(a) RESIDENCE. No. 1519 Friendship ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 5 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	— 1 —	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 070

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer City Street Cleaning Dept Baltimore

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Peter McCormack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thomas Mack (Address) Washington Co.

15 Filed 10 Robert P. Harrison Registrar

OCT 28 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28. 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 25th, 1920, to Oct 28th, 1920, that I last saw him alive on Oct 28th, 1920, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 2 yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? — no —

What test confirmed diagnosis? Clinical & Urinalysis.

(Signed) Wm J Swanson M. D.

(Address) 170 McFulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Oct 29 1920

20 UNDERTAKER Wm. Fabers Sons ADDRESS 207 W. Mt. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47643 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47643

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St. 12 WARD) 79

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas F. Dunn

(a) RESIDENCE. NO 2419 Francis St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED Retired Watchman

(a) Trade, profession or particular kind of work United Railway Co.

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co Md

PARENTS

10 NAME OF FATHER Edward Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant John Dunn

(Address) 2419 Francis St

15 Filed OCT 28 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1920, to Oct. 26, 1920, that I last saw him alive on Oct. 26, 1920, and that death occurred, on the date stated above, at 4 50 P. m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Frank C. Marino, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bd Charles Palmerville Md	Oct 29 1920
20 UNDERTAKER	ADDRESS
Wm Fahey & Sons	1827 W North Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S item of

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 47644

CERTIFICATE OF DEATH.

143808 D. 47644

81

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Brown.

(a) RESIDENCE. NO. 13 Church St. City. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?. 1857

7 AGE Absut	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Trimmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?.

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown.

12 MAIDEN NAME OF MOTHER Priscilla Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Jtt. (Address)

15 Filed ..... 19.... [Robert P. Harrigan] Registrar

OCT 28 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1920, to Oct. 26, 1920, that I last saw him alive on Oct. 26, 1920, and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 2+ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Mason, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Oct 29 1920
20 UNDERTAKER	ADDRESS
J. L. Brown & Son	118 N Monty Av

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47645 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47645

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 N Wolfe St. 6 99 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Marie Hall

(a) RESIDENCE. No. 706 N Wolfe St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A Hall

6 DATE OF BIRTH (month, day, and year) May 22, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robt M Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Katherine Mueller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) James A Hall 706 N Wolfe

15 Filed OCT 28 1920 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 10 1920 to Oct 27 1920 that I last saw h[illegible] alive on Oct 27 1920 and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 8 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John J Neal M. D.

10/28 1920 (Address) 936 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Oct 29 1920
20 UNDERTAKER	ADDRESS
J Kemp's Sons	200 Eden

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47646 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47646

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 432 813 St ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Howard Taylor

(a) RESIDENCE. NO. 732 813 ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Henry H Taylor

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Lillian E Meisenhelder

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant: Lillian E Taylor
(Address) 732 S. 13 St

15 Filed ..., 19 ... Registrar

(Robert P. Harrison,
Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1920

17 I HEREBY CERTIFY, That I attended deceased from October 7, 1920, to October 26, 1920, that I last saw him alive on ..., 19..., and that death occurred, on the date stated above, at 4.20 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Chronic

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Patent ventricular septum

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lawson Wilkins M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Oct 29 1920
20 UNDERTAKER J Hervey & Co	ADDRESS 2008 Mass Ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47647

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47647

CERTIFICATE OF DEATH.

1920

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2007 Penrose Ave ST. 20 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary F Claude

(Residence in Baltimore: No. 2007 Penrose ave St.; 6 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, May (Month) 19 (Day), 1869 (Year)

7-AGE, 51 yrs. 5 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), in U.S.A. 50 years Scotland

PARENTS.

10-NAME OF FATHER, Michael Gannon

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Margaret Mullaney

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Newett Wood

(Address) 2007 Penrose ave

15-

Filed OCT 28 1920, 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 27th (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 1914, to Oct 27th 1920, that I saw h[illegible] alive on Oct 27th 1920, and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

History (Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Emphysema

(Duration) 4 yrs. 4 mos. ds.

(Signed) Henry B Kolb M. D.

Oct 28th, 1920. (Address) 120 3 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Annapolis Md. DATE OF BURIAL, Oct 29, 1920

20-UNDERTAKER Geo. A. Gerbig 2001 W. Baltimore St. ADDRESS

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.47648

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.47648

CERTIFICATE OF DEATH.

28

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isarel Preston

(a) RESIDENCE. No. 557 Union St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 140

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER John Preston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Anna Hempfill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) M.T.H.

Filed OCT 28 1920, 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25, 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1920, to Oct. 25, 1920, that I last saw him alive on Oct. 24, 1920, and that death occurred, on the date stated above, at 12.30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum

(Signed) L. J. Rigney, M. D.

10-25-20, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL OCT 2 1920, 19

20 UNDERTAKER Commissioner Health,

ADDRESS

Robert T. Morrison

THION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47649 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47649

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1838 W Franklin St. 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME George H. Lewis

(a) RESIDENCE. No. 1838 W Franklin ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 16 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Van god

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Geo. H. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Rebecca Harper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Nellie A Lewis
(Address) 1838 W. Franklin St

15 Filed OCT 28 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1920, to Oct 28, 1920, that I last saw h alive on Oct 28, 1920, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Primary Arteriosclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Homer C. Good, M. D.

10/28, 1920 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 30 1920
20 UNDERTAKER	ADDRESS
Geo. J. Smith	1000 W. Fayette.

IRON is very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified.

(Eldred G. Shriver)

D.47650 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47650

3601 E. Lombard st.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3601 E Lombard St.; 1st WARD)

REGISTERED No. C 10352

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eldred G Shriver

(Residence in Baltimore: No. 415 East Pt St Ofpaul St. or R.F.D. No.) Years 2 mos. 6 ds. (6 days)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male	White	Single

6-DATE OF BIRTH, ... (Month) Sept (Day) 7, (Year) 1914

7-AGE, ... 6 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles L Shriver

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Dora M Gladfelter

13-BIRTHPLACE OF MOTHER (State or Country), Lebanon Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles L Shriver

(Address) 415 East Pt St P.D

15-

Filed ..... 191 ..... Robert P. Harrison
Registrar.

OCT 28 1920
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 27, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Ward Dunkley M. D.
(Coroner)
Oct 28, 1920 (Address) 1800 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 415 Shannon St. Balto

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cemetery	Oct 29, 1920
20-UNDERTAKER	ADDRESS
John F Denny	715 Light St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Rks.

D.47651 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47651

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 738 S. Edwood Ave St. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annette A. Jones

(a) RESIDENCE. No. 738 S. Edwood Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) July 11, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER J. Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Charles W. Jones

(Address) 738 S. Edwood Ave

15 Filed . 19 Robert P. Harrison

Registrar

OCT 22 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27 1920

17

I HEREBY CERTIFY, That I attended deceased from April 16 , 1920 , to Oct. 27 , 1920 ,

that I last saw h[illegible] alive on Oct. 27 , 1920 ,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. M. Pettigrew , M. D.

, 19 (Address) 817 Hamilton Terrace

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Oct 30 1920
20 UNDERTAKER	ADDRESS
John F Denny	715 Light

...should state ...act statement of OCCUPA- ...it may be properly classified. TION is very important. See instructions on back of certificates.

D47652 HEALTH DEPARTMENT—CITY OF BALTIMORE D47652

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 875 W. Lombard ST.: 18 WARD) REGISTERED No. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Helen Collins

(Residence in Baltimore: No. 875 W Lombard St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Jan (Month) 8 (Day), 1879 (Year)

7-AGE, 41 yrs. 9 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm Daly

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Bridget Brown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Emma F. Daly

(Address) 2707 Greenmount Ave

15- OCT 29 1920

Filed....., 191..... ROBERT P. KRANTZ

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy or inquiry.)~~ find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Edwardian disease of the heart

(Duration) a few mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) W K Gornick M. D.
(Coroner.)

10-28-1920 (Address) 11 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem	Oct 30" 1920
20-UNDERTAKER Joseph B Cook	ADDRESS 1003 N. Paca

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

~~1947653~~ HEALTH DEPARTMENT—CITY OF BALTIMORE ~~1947653~~

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C 79

CITY OF BALTIMORE (No. William & York Sts. ST.: 25th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Davis.(C). 42 ---------.

(Residence in Baltimore: No. 108 Winter St. St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH, ...Do not know....., 1..... (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
42 yrs. --- mos. --- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....Laborer.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Charles Davis.(C).

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER Emma ---------.(C).

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rachael Carr.(C).(cousin).

(Address).....1015 Race St.....

15- OCT 29 1920 ROBERT B KRAUTER

Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...October 25th 1920....., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.....) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....Valvular disease of the heart.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Oct. 27th 1920 (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Albion	Oct. 28, 1920
20-UNDERTAKER R. J. Parkam	ADDRESS 649 W. Lee St.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47654

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47654

CERTIFICATE OF DEATH

REGISTERED NO. 103

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 Woodbourne ave ST.: Govans WARD)

2-FULL NAME Virginia Clark Bamberger.

(a) RESIDENCE. No. 620 Woodbourne ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph W Bamberger

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
59.	Aug.	26th	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Edwin R Poole

11 BIRTHPLACE OF FATHER (city or town) Charlestown
(State or country) Va.

12 MAIDEN NAME OF MOTHER Susan Eager

13 BIRTHPLACE OF MOTHER (city or town) Alexandria
(State or country) Virginia

14 Informant Frank Bamberger
(Address) 620 Woodbourne ave

15 Filed OCT 29 1920 ROBERT T. NEAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1920, to Oct. 29, 1920, that I last saw h.... alive on ...., 19...., and that death occurred, on the date stated above, at 12 10 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? ---

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? ---

(Signed) H W Kous., M. D.

10-29 1920 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 1920
20 UNDERTAKER	ADDRESS
C A Wiedefeld Jr	501 E 25th St

8

AGE should be stated EXACTLY. PHYSICIANS should state so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so th... ation should be carefully supplied. AG...

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Had eaten grated cocoanut & heavy potpie supper.

D47655 HEALTH DEPARTMENT—CITY OF BALTIMORE D47655

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1143 N. Mount ST. 16 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel James Shield

(Residence in Baltimore: No. 1143 N. Mount St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July 16, 1850
(Month) (Day) (Year)

7-AGE, 70 yrs. 3 mos. 12 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: retired 062
(b) General nature of industry, business, or establishment in which employed (or employer): Watchman

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Samuel Shield

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Mary James

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Samuel Shield

(Address) 1143 N. Mount

15- OCT 29 1920 ROBERT E LEAUTER
Filed, 191. Registrar.
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 28, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) jury, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
5 minutes

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Oct. 28, 1920 (Address) 2802 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Va. DATE OF BURIAL, Oct. 29, 1920

20-UNDERTAKER Williams Cook ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1047656 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047656

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 2-E-25th St. (Ward) 12 REGISTERED No. C 79
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Lord.

(Residence in Baltimore: No.) 2-E-25th St.

St. yrs., 10 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, C

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, Not known, (Month) (Day) 1 (Year)

7-AGE, 48 yrs. mos. ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Butler
(b) General nature of industry, business, or establishment in which employed (or employer). Private family

9-BIRTHPLACE. (State or Country) West Indies -

PARENTS.

10-NAME OF FATHER, Not known.

11-BIRTHPLACE OF FATHER (State or Country) West Indies

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country) Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. McDevitt

(Address) 2 E 25th St

15-

Filed OCT 29 1920, 191 ROBERT B. KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 27 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. ds.

(Signed) Geo. Guthrie Blade M. D.
(Coroner.)

10/28/, 191 (Address) 1713 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel cmty DATE OF BURIAL, Oct 27, 1920

20-UNDERTAKER Mrs Robt Elliott ADDRESS 1725 Eastland ave

CAUSE OF DEATH in plain terms, so that it may be correctly supplied. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

047657 HEALTH DEPARTMENT—CITY OF BALTIMORE 047657

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH 1840 Wilkens Ave

CITY OF BALTIMORE: (No. 1840 ST.: 19 WARD) REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME David Andrews

(a) RESIDENCE. No. 1840 Wilkens Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 7 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Annie L. Andrews

6 DATE OF BIRTH (month, day, and year) March 15, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	7	13	

8 OCCUPATION OF DECEASED 031

(a) Trade, profession or particular kind of work Retired Machinest

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad Machinest

(c) Name of employer B & O. R.R.

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Stephen Andrews

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth L. Brown

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Annie L. Andrews
(Address) 1840 Wilkens Ave

15 Filed OCT 29 1920, 19.... Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28 1920

17 I HEREBY CERTIFY, That I attended deceased from October 14, 1920, to October 28, 1920, that I last saw him alive on October 28, 1920, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Asa L. Wessels, M. D.

10-28 1920 (Address) 2565 Fredericks Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Oct. 30 1920
20 UNDERTAKER	ADDRESS
Geo. W. Linde	531 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47658

HEALTH DEPARTMENT—CITY OF BALTIMORE

28 D 47658

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 233 N. Dunham ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Moore

(a) RESIDENCE. No. 233 N. Dunham ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) general

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Thomas Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Lucy Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Clark Moore (Address) 426 N. Dunham St

15 Filed OCT 29 1920 19 ROBERT H. EBAUGH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27, 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug. 3, 1920 to Oct 27, 1920

that I last saw him alive on Oct. 27, 1920

and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Phthisis pulmonalis

(duration) yrs. 2 mos. da.

CONTRIBUTORY (Secondary) Subacute bronchitis

(duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. B. Lewis M. D.

(Address) 530 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Oct 30 1920

20 UNDERTAKER Milton Davis ADDRESS 413 N. Eden St

CAUSE OF DEATH in plain terms. ANY abbreviation or illegible entry will be returned for information. Should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

U.S. AEF

Spec.—8-24-14—M. & T.—2000 Bks.

D47659

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47659

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 502 Eutaw [illegible] ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas. C. MacDonald

(Residence in Baltimore: No. 150 a Eutaw Park Ave St.; 1 yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, about 58 yrs. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Ship 1/15

9-BIRTHPLACE, (State or Country), Prince Edward Isl. Canada

PARENTS.

10-NAME OF FATHER, Chas. P. MacDonald

11-BIRTHPLACE OF FATHER (State or Country), Canada

12-MAIDEN NAME OF MOTHER Catherine McNeal

13-BIRTHPLACE OF MOTHER (State or Country), Canada

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. E. MacDonald

(Address) 191 Wash. St., Quincy Mass

15-

Filed ..... 191.....

ROBERT B. KRAUTER
Registrar.

OCT 29 1920
Marital Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) 10 (Day) 28, (Year) 1920

17. I HEREBY CERTIFY, That I attended deceased from Oct 23 1920, to Oct 28 1920, that I saw h[illegible] alive on Oct 23 1920, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

1. Cardiac Insufficiency

2. Valvular Insufficiency

3. .....

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Oct 29, 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Quincy Mass

DATE OF BURIAL, Oct 30, 191...

20-UNDERTAKER M. L. Flynn

ADDRESS 1422 Light St

IMPORTANT: PHYSICIANS should state diseases in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047660

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047660

CERTIFICATE OF DEATH.

45

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 341 W. Dolphin ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Marshall

(a) RESIDENCE. NO. 341 W. Dolphin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 12 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager - Central

(b) General nature of industry, business, or establishment in which employed (or employer) Stables 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Easton, Talbott Co. Maryland

PARENTS

10 NAME OF FATHER ------- Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Easton, Maryland

12 MAIDEN NAME OF MOTHER ----- Ellsby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Easton, Maryland

14 Informant Mrs. Dora Keeling
(Address) 341 W. Dolphin Street

15 Filed OCT 29 1920 29 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27th 1920

17

I HEREBY CERTIFY, That I attended deceased from August 27 1920, to Oct 27th 1920, that I last saw him alive on Oct 26th 1920, and that death occurred, on the date stated above, at 9a P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Pancreas with involvement of adjacent tissues producing jaundice & emaciation

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Palpable mass & jaundice

(Signed) Chas. O'Donovan, M. D.

Oct 29 1920 (Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	10/29 1920
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D47661

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47661

41

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 S. Eden ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Wachowicz

(a) RESIDENCE. No. 104 S. Eden ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan - 1847

7 AGE: Years 73; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Josephine Wachowicz

(Address) 104 S Eden St-J

15 Filed OCT 20 1920, 19 ROBERT P. LEMMEN Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 1920, to Oct 27 1920, that I last saw her alive on Oct 27 1920, and that death occurred, on the date stated above, at 1145 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cecum

17 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) W J Baylis, M. D.

10/27/20 (Address) 210 Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Hall, Kent Co Md.	Oct 29 1920
20 UNDERTAKER	ADDRESS
H E Hughes	17 E Broadway

TION is very important. See instructions on back of certificates. it may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047662 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047662

CERTIFICATE OF DEATH.

REGISTERED NO. 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1203 Wall St.: 24 WARD)

2-FULL NAME Edith Dorothy Stewart

(a) RESIDENCE. No. 1203 Wall ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE white | 5 Single, ~~Married, Widowed, or Divorced~~ (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 3, 1920

7 AGE | Years 0 | Months 7 | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— ooo

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Maurice Otis Stewart Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Md.

12 MAIDEN NAME OF MOTHER Blanche Goldie Summers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Crisfield Md

14 Informant Mamie A. Edwards
(Address) 1203 Wall St

15 Filed OCT 29 1920 19 ROBERT E. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1920, to Oct. , 1920, that I last saw her alive on Oct. 28, 1920, and that death occurred, on the date stated above, at 5.15 a m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard L Tolson, M. D.

(Address) 1213 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Oct 30 1920

20 UNDERTAKER E & B Hasle ADDRESS 115 E Wash St

Marriage should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D47663 HEALTH DEPARTMENT—CITY OF BALTIMORE D47663

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH Woman's Hospital REGISTERED NO. C

CITY OF BALTIMORE: (No. ..... St.; 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Florence B. Wood.

(Residence in Baltimore: No. Montreal apts St.; 27 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~, (*Write* the word.) widow

6-DATE OF BIRTH, May 8, 1893
(Month) (Day) (Year)

7-AGE, 27 yrs. 5 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lady
(b) General nature of industry, business, or establishment in which employed (or employer): HH

9-BIRTHPLACE, (State or Country), Penn.

PARENTS.

10-NAME OF FATHER, William Bell

11-BIRTHPLACE OF FATHER (State or Country), Penn.

12-MAIDEN NAME OF MOTHER Hannah Brown

13-BIRTHPLACE OF MOTHER (State or Country), Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs B Wood

(Address) Montreal apts

15- OCT 29 1920 ROBERT E KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 2, 191..., to Oct. 29 1920, that I saw her alive on Oct. 28 1920, and that death occurred, on the date stated above, at 12 15 (a) m.

The CAUSE OF DEATH* was as follows:

Uraemia

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Int. ast. in chr. nephritis and operation

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Frank C. Wharton M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 2 6 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence Montreal apts

19-PLACE OF BURIAL OR REMOVAL, Philadelphia Pa — DATE OF BURIAL, Oct. 30, 1920.

20-UNDERTAKER Henry W. Frank Sons Co — ADDRESS McCulloh St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

Chr. nephritis Operation for obstruction

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

1047664 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047664

CERTIFICATE OF DEATH.

X 64

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Womens Hospital 7th ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Berky

(Residence in Baltimore: No. 515 Cathedral St. St.; yrs., mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	widowed

6-DATE OF BIRTH, September 11, 1852
(Month) (Day) (Year)

7-AGE, 68 yrs. 1 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Hudson, N. Y.

PARENTS.

10-NAME OF FATHER, John Hunter Gould

11-BIRTHPLACE OF FATHER (State or Country), Newport, R. I.

12-MAIDEN NAME OF MOTHER Hannah Wright

13-BIRTHPLACE OF MOTHER (State or Country), New York, N.Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. C. Kahl

(Address) New York To Womens Hosp.

15-

OCT 29 1920

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 28, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
9 hrs.
(Duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis.
(Duration) yrs. mos. ds.

(Signed) J. D. Hennessy M. D.
(Coroner.)

Oct. 28, 1920 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.1...ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 516 Cathedral St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hudson Columbia County New York	10-29-1920
20-UNDERTAKER Henry W. Jenkins Son Co	ADDRESS Orchard McCulloh St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47665 HEALTH DEPARTMENT—CITY OF BALTIMORE D47665

CERTIFICATE OF DEATH.

91 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 N. Milton Ave. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Graf

(a) RESIDENCE. No. 228 N. Milton Ave St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Graf.

6 DATE OF BIRTH (month, day, and year) July 26, 1841

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Graf

(Address) 228 N. Milton Ave

15 Filed OCT 29 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27- 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4- 1920, to Oct 27- 1920, that I last saw h- alive on Oct 27- 1920, and that death occurred, on the date stated above, at 10 45 p.m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(Senile Bronchitis)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) General Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home -

Did an operation precede death? No Date of -

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Frank Bruner, M. D.

. 19 (Address) 125 E Biddle -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Oct 30, 1920
20 UNDERTAKER	ADDRESS
Philip Herwig	2016 Orleans St.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47666 ✓D.47666

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto. Gen. Hospital St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phillip Ischer

(a) RESIDENCE. NO. 1733 N. Patterson Park Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. + mos. ds. How long in U. S., if of foreign birth? 50 yrs. + mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elizabeth Ischer

6 DATE OF BIRTH (month, day, and year) Jan 15. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Ofc

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Switzerland.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant Elizabeth Ischer
(Address) 1733 N. Pat. Pk Ave

15 Filed ..... 19 Registrar

OCT 29 1920 Robert P. Harrison, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27. 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16. 1920. to Oct. 27. 1920. that I last saw h im alive on Oct. 27. 1920. and that death occurred, on the date stated above, at 5.25 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus. (Inoperable)

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Laparotomy & Jaundice

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy?

What test confirmed diagnosis? Erosion of heart & respiratory organs

(Signed) Robt W Johnson M.D.

. 19 (Address) So Balto Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	Oct 30 1920
20 UNDERTAKER Philip Herrig	ADDRESS 2016 Aliceanna

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47667 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47667

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital St. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Kate Sullivan

(a) RESIDENCE. No. 3839 Dalrymple Ave. - WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 3 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced (or) WIFE of Alfred E Sullivan

6 DATE OF BIRTH (month, day, and year) July 6th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Octavius J. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Annie McWilliams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Alfred E Sullivan

(Address) 3839 Dalrymple Ave

15 Filed OCT 29 1920 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27 / 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct. 18 - 1920, to Oct. 27 / 1920, that I last saw her alive on Oct. 27 / 1920, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Chron. Myocarditis -

Fibroid Uterus

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? - Balt. Md -

Did an operation precede death? Yes Date of 10/27/20

Was there an autopsy? Yes - Partial

What test confirmed diagnosis? Clinical Test -

(Signed) Philibert Artigiani, M. D.

(Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Oct 30th 1920
20 UNDERTAKER	ADDRESS
George Schilling & Son	1126 E Monument St

TION is very important. See instructions on back of certificates.

D. 47668 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 47668

CERTIFICATE OF DEATH. X 91

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 949 Pen Alley ST.) 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Harris

(Residence in Baltimore: No. 949 Pen Alley St.; yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 1 (Day), 1920 (Year)

7-AGE, 0 yrs. 3 mos. 26 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer) Infant

9-BIRTHPLACE, (State or Country) Youngstown, Ohio

PARENTS.

10-NAME OF FATHER, James Harris

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER Viola Harris

13-BIRTHPLACE OF MOTHER (State or Country), N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola Harris

(Address) N. Carolina

15-

Filed ....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH October 27, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) No history

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Hennessy, M. D.
(Coroner.)

(Address) 2802 Eastern Ave.

Oct 27 1920

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, HOPKINS HOSPITAL

DATE OF BURIAL, ..., 19....

20-UNDERTAKER Commissioner Health,

ADDRESS

OCT 29 1920

Robert P. Harrison, JOHNS

OCT 29 1920 Burial Permit Clerk

17611

WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

D.47669 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47669

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 S. Exeter St.; 3 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antonietta Mabriciani

(Residence in Baltimore: No. 229 S. Exeter St.; ....yrs.,....mos.....ds.)

Be sure that statement of OCCUPATION is very complete. Read instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Dec. (Month) 31 (Day), 1919. (Year)

7-AGE, ...yrs. 9 mos. 29 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none (HD)
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Mabriciani

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Lucy Ferretti

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Mabriciani

(Address) 229 S. Exeter St.

15-

Filed OCT 29 1920, 191....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1920, to Oct. 29, 1920, that I saw her alive on Oct 28 - 1920, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Uraemia - Eclampsia

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Eugene L. Pessagno M. D.

Oct. 29, 1920 (Address) 2314 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery — DATE OF BURIAL, Oct. 30, 1920

20-UNDERTAKER William J. Schaeffer — ADDRESS 816 Monument

Spec.—8-24-14—M. & T.—2000 Bks.

D.47670 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47670

91-089

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 137 W. Henrietta ST.; 23 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Henry Boone

(Residence in Baltimore: No. 137 W Henrietta St.; ..... yrs., 8 mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, March 5th, 1920
(Month) (Day) (Year)

7-AGE, — yrs. 8 mos. 23 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ooo

9-BIRTHPLACE, (State or Country), md.

PARENTS.

10-NAME OF FATHER, Harrison Boone

11-BIRTHPLACE OF FATHER (State or Country), md.

12-MAIDEN NAME OF MOTHER Etta Bannister

13-BIRTHPLACE OF MOTHER (State or Country), md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harrison Boone

(Address) 137 W Henrietta.

15- Filed ..... 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 28th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 25th 1920, to Oct 28th 1920, that I saw him alive on Oct 28th 1920, and that death occurred, on the date stated above, at 10.30a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) about one week yrs. ..... mos. ..... ds.

(Signed) J. Gunby Burley M. D.

10/29/, 191.. (Address) 908 S Eden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL.
Mt Auburn ✝	Oct 30., 1920
20-UNDERTAKER	ADDRESS
Wm. Brown & Son	1081 W. Monty St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47671

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47671

45

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH Women's Hospital

CITY OF BALTIMORE: (No. Cor. Johns & Lafayette Ave. ST.; 11 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Nannie Ravenscroft Boswell

(Residence in Baltimore: No. 6 East Centre St. (The Albany) St.; 41 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	single

6-DATE OF BIRTH, March ?, 1854
(Month) (Day) (Year)

7-AGE, 66 yrs. 7 mos. ? ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), North Carolina.

PARENTS.

10-NAME OF FATHER, William C. Boswell

11-BIRTHPLACE OF FATHER (State or Country), Lunenburg Co. Virginia

12-MAIDEN NAME OF MOTHER Mary Armistead Bumwell

13-BIRTHPLACE OF MOTHER (State or Country), Mecklenburg Co. Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R.P. Harrison

(Address) Women's Hospital

15-

Filed OCT 30 1920, 191.....

Robert P. Harrison,
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1920, to Oct 29, 1920, that I saw h-r alive on Oct 29, 1920, and that death occurred, on the date stated above, at 9.27 A m.

The CAUSE OF DEATH* was as follows:

Primary Carcinomatosis

? ? ?
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Secondary anemia

? ? ?
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Bruce D. Wallace M. D.

Oct 29, 1920 (Address) Women's Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 16 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence 6 East Centre St. Balto

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery. | DATE OF BURIAL, 10.30, 1920

20-UNDERTAKER Henry W. Miles & Son | ADDRESS 805 N. Calvert St.

Important.—See instructions on back of certificate.

D.47672 HEALTH DEPARTMENT—CITY OF BALTIMORE D47672

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH
CITY OF BALTIMORE (No. At or on way to Mercy Hospital WARD)
REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry J. Michael.
(Residence in Baltimore: No. 216 W. Madison St.; 62 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, April (Month) 17 (Day), 1858 (Year)

7-AGE 62 yrs. 6 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry J. Michael
11-BIRTHPLACE OF FATHER (State or Country), Md
12-MAIDEN NAME OF MOTHER Sarah J. Michael
13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Mary J. Miller
(Address) 3501 Harlem Ave

15-
Filed OCT 30 1920, 19... Robert P. Garrison
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Sudden (Duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.
(Signed) [illegible] M. D.
(Coroner.)
Oct. 29, 1920 (Address) 1655 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Green Mount Cem	Oct 30, 1920
20-UNDERTAKER John D. Mitchell	ADDRESS 1701 W. Fay. Ave

IMPORTANT.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47673

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47673

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2301 N. Charles ST.: 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joachim Fogarty

(Residence in Baltimore: No. 2301 N. Charles St.: 75 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April (Month) 9 (Day), 1842 (Year)

7-AGE, 78 yrs. 6 mos. 19 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), ~~Ireland~~ Baltimore Md

PARENTS.

10-NAME OF FATHER, Philip Fogarty

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Phoebe Hill

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Recorder of Baltimore

(Address) 2301 N. Charles St

15- Robert P. Harrison.

Filed OCT 30 1920, 191.....

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 22 1920, to Oct 28 1920, that I saw h[er] alive on Oct 28 1920, and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A F Robinson M. D.

Oct 29, 1920 (Address) 1307 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem

DATE OF BURIAL, Oct 30, 1920

20-UNDERTAKER John C Mitchell

ADDRESS 17 W. Fayette

important. See instructions on back of certificate.

D.47674 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47674

CERTIFICATE OF DEATH.

REGISTERED No. C 175.001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Receiving Ward Fort McHenry St.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick C. Bosch

(Residence in Baltimore: No. 1470 Stevenson St. St.: 8 yrs., 1 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, September 5th. 1912, 1
(Month) (Day) (Year)

7-AGE, 8 yrs. 1 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None. 0.0.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Emil Bosch.

11-BIRTHPLACE OF FATHER (State or Country), Belgium.

12-MAIDEN NAME OF MOTHER Louisa Schneider.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emil Bosch (father)

(Address) 1470 Stevenson St.

15- Robert F. Harrison,

Filed ..... 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 27th. 1920. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Injuries.
Accidentally struck and run over by Automobile truck License #9-920

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Oct. 28.... 1920. (Address) 1617 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem. DATE OF BURIAL, Oct 30 1920

20-UNDERTAKER Margaret E. Flynn ADDRESS 1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47675 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47675

150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1632 E. Clement ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander J. Staaps.

(a) RESIDENCE. No. 1632 E. Clement ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 25th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm. F. Staaps.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary J. Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Wm F. Staaps.

(Address) 1632 E. Clement St

Dec 30 1920 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1920 19

17

I HEREBY CERTIFY, That I attended deceased from Oct. 28½, 1920, to Oct. 29½, 1920 that I last saw him alive on Oct. 28, 1920, and that death occurred, on the date stated above, at 3. A. m.

The CAUSE OF DEATH* was as follows:

Paleness of the forearm Broken.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I. A. Shipyard, M. D.

Dec. 30 1920 (Address) 423 E. Fort Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Oct 30 1920
20 UNDERTAKER Manuel G. Flynn	ADDRESS 1422 Ryder St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47676

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47676

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Vincent Asylum St. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Mary McNeal

(a) RESIDENCE. No. St Vincent Asylum ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Oct 27 1920

7 AGE	Years	Months	Days	If LESS than 1 day 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nw

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Mary McNeal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant St Vincent Asylum (Address) 1401 Dennison St

15 Filed Oct 30 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1920, to Oct 27, 1920, that I last saw her alive on Oct 27, 1920, and that death occurred, on the date stated above, at 10 30 m.

The CAUSE OF DEATH* was as follows:

Premature Birth
6 months 4 lbs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? nw Date of —

Was there an autopsy? nw

What test confirmed diagnosis? Clinical

(Signed) Chas P Hamilton M. D.

(Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Oct 30 1920

20 UNDERTAKER M Fahey Sons — ADDRESS 1827 W Baltimore

OCT 30 1920

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.47677 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.47677

CERTIFICATE OF DEATH. 50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 E. Lanvale ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert L. Thompson Sr

(a) RESIDENCE. No. 415 E. Lanvale ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara A. Thompson

6 DATE OF BIRTH (month, day, and year) March 8-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ice Cream Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Daniel Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant: Barbara A. Thompson (Address) 415 E. Lanvale St

15 Filed 19 Registrar

Robert P. Harrison,

Burial Permit 12 3rd St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29th 1920

17 I HEREBY CERTIFY, That I attended deceased from June 30th, 1920, to Oct 29th 1920.

That I last saw him alive on Oct 28th, 1920.

and that death occurred, on the date stated above, at 3-40 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) about 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) W A Fair M. D.

10/29 1920 (Address) 12 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Nov 1 1920

20 UNDERTAKER H. C. Wiedefeld ADDRESS 914 Greenmt Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CT 30 1920

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47678

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47678

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 N. Chapel ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Walters Gaston

(a) RESIDENCE. NO. 624 N Chapel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Gaston

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
39	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic '07 0

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer Balto

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm. James Walters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Willie Miller

(Address) 624 N. Chapel st.

Filed OCT 30 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1920, to Oct. 28, 1920

that I last saw h[illegible] alive on Oct. 28, 1920

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno B Robinson M. D.

(Address) 522 Monument E

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem,	Nov 1st 1920

20 UNDERTAKER Harry A Vodery ADDRESS 1923 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47679

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D47679

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 Presstman ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura G. Brown

(a) RESIDENCE. No. 1410 Presstman ST., 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept 3, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Cook 121

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joshua Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriet Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Laura G. Brown (Address) 1410 Presstman

15 Filed OCT 30 1920 19 Registrar Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1920, to Oct 27, 1920, that I last saw h alive on Oct 26, 1920, and that death occurred, on the date stated above, at 9.58 A m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Etc (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? City.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Wm. H. Wright M. D.

Oct 27. 1920 (Address) 1209 Pressman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Piney Grove	Oct 30 1920
20 UNDERTAKER	ADDRESS
Edw. Ruggold.	1462 Carey St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D47680

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47680

CERTIFICATE OF DEATH.

91

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Parrish ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Russell Bayer

(Residence in Baltimore: No. 1102 Patrish St.; ....yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) baby

6-DATE OF BIRTH, March 2 (Month) 29 (Day), 1920 (Year)

7-AGE, ...yrs. 7 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work baby 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, William Bayer

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Ethel C. Scribner

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Hall

(Address) 1102 Parrish

15- Filed OCT 30 1920, 191.... Robert P. Harrison, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 28 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 25 1920, to Oct 28 1920, that I saw h[illegible] alive on Oct 28 1920, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Over

Bronchio-Pneumonia

(Duration) ....yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Charles E. Clark M. D.

Oct 29, 1920 (Address) 1306 N. Gilmor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Oct 29, 1920

20-UNDERTAKER Edw. Ringgold

ADDRESS 1463 Carey St

important. See instructions on back of certificate.

(over)

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47681

CERTIFICATE OF DEATH.

28 D 47681

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2577 W. Fayette ST. 00 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kladsner

(a) RESIDENCE. NO. 2577 W. Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Klausner

6 DATE OF BIRTH (month, day, and year) Jan. 7. 187-

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4.-	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— 000

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Georg Baldeymer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kath. Nadelein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Barbara Medes (Address) 2577 W. Fayette St

15 Filed OCT 30 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 28 1920

17 I HEREBY CERTIFY, That I attended deceased from October 27th 19 20, to Oct. 28 19 20, that I last saw h[illegible] alive on Oct. 27 19 20, and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Peritonitis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 4. 1920

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. J. Marr M. D.

10-30 1920 (Address) 827 E. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 30 19 20
20 UNDERTAKER	ADDRESS
H. D. Hapgood	1336 Fred'k Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D47682

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47682

64

CERTIFICATE OF DEATH.

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1521 Shield Alley St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Henrietta Halley

(Residence in Baltimore: No. 1521 Shield Alley St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, May (Month) 25 (Day), 1867 (Year)

7-AGE, 53 yrs. 5 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry Bolden

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Matilda Neale

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lilly Valley

(Address) 1303 Upshur St

15-

OCT 30 1920

Filed....., 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 29 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
5 minutes
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) and Cirrhosis
(Duration) yrs. mos. ds.

(Signed) J. C. O'Hennessy M. D.
(Coroner)

Oct. 29 1920, 191.. (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Peters Cmtry

DATE OF BURIAL, Nov 1, 1920

20-UNDERTAKER J Irvin Hall

ADDRESS 1741 Pennsylvania Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47683

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47683

CERTIFICATE OF DEATH.

179

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hosp. St. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Szeliga

(a) RESIDENCE. No. 2320 Fleet ST. 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherina Szeliga

6 DATE OF BIRTH (month, day, and year) Unknown 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Copper Works

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER William Szeliga

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Mary Bajko

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Ulyanger Pest (Address) 2320 Fleet St.

15 Filed OCT 30 1920 Robert P. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28, 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1920, to Oct. 28, 1920, that I last saw h[illegible] alive on Oct. 28, 1920, and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Bethlehem Steel Co.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) H. M. Bubert, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Oct 30 1920
20 UNDERTAKER Jacob Tait's Sons	ADDRESS 1128 E. Monument

IMPORTANT.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.47684

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47684

CERTIFICATE OF DEATH.

OK W.K. Jonah Coroner

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. University of Maryland Hospital ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Rhodes

(Residence in Baltimore: No. 1626 Bruce St. St.; 20 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. Colored.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. October, (Month) (Day) 1891 (Year)

7-AGE. 29 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. 040
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER. Charles Rhodes.

11-BIRTHPLACE OF FATHER (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER Clemmie Abner.

13-BIRTHPLACE OF MOTHER (State or Country). Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Rhodes

(Address) 1526 Bruce St

15- Robert P. Harrison,

Filed ..... 191.... Registrar.

OCT 30 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 28th (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 26th 1920, to Oct 28th 1920., that I saw him alive on Oct 28th 1920, and that death occurred, on the date stated above, at 4:20 p.m.

The CAUSE OF DEATH* was as follows:

Acute Cocaine Poisoning (Accidental)-

over

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) yrs. mos. da.

(Signed) [illegible] M. D.

10/29, 1920 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 3 da. In the State 20 yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Mt Auburn. DATE OF BURIAL. Oct 31, 1920.

20-UNDERTAKER Edw. Finggold ADDRESS 1463 Carey St

important. See instructions on back of certificate.

Remarks This man had a stricture and was going to have operation on - an internal urethrotomy to be done - cocaine was injected into urethra and patient collapsed shortly afterward. - Gonococcus Infection

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47685

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47685

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 160 Dolphin St. 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Morton

(Residence in Baltimore: No. 160 Dolphin St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, 19th Nov, 1919
(Month) (Day) (Year)

7-AGE, X yrs. 11 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Henry Morton

11-BIRTHPLACE OF FATHER (State or Country), Balto, Md.

12-MAIDEN NAME OF MOTHER Hannah Nixon

13-BIRTHPLACE OF MOTHER (State or Country), Balto, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hannah Nixon

(Address) 160 Dolphin St

15-

Filed OCT 20 1920, 191.....

Robert P. Harrison,
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 19th, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10th 1920 to Oct 19th 1920, that I saw h[illegible] alive on Oct 18th 1920, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Oct 19, 1920 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Oct 20, 1920

20-UNDERTAKER Daniel Easter

ADDRESS 916 Penna Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

29.47686 HEALTH DEPARTMENT—CITY OF BALTIMORE 29.47686

CERTIFICATE OF DEATH. 45

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest S. Henry.

(a) RESIDENCE. No. 1616 W. Franklin St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed OCT 30 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29, 1920

17 I HEREBY CERTIFY, That I attended deceased from October 26, 1920, to October 29, 1920, that I last saw him alive on October 28, 1920, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Carcinomatosis.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Microscopic Test

(Signed) [illegible], M. D.

10/29/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible]	Oct 31 1920
20 UNDERTAKER	ADDRESS 916
David Easton	Penna Ave

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.47687 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47687

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 935 N. Gallas ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Bischoff

(a) RESIDENCE. No. 935 Dallas ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact [illegible] of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Bischoff

6 DATE OF BIRTH (month, day, and year) Sept 25. 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Dchester Md

PARENTS

10 NAME OF FATHER Aquilla Frederick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Armir Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Frank Bischoff

(Address) 16 W. Cross St ff

15 Filed OCT 30 1920 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29. 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1920, to Oct 29, 1920, that I last saw her alive on Oct 28, 1920, and that death occurred, on the date stated above, at 12:35A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency (General anasthesia)

(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Typical Symm.

(Signed) Jno A Chetroker, M. D.

19 (Address) 10 25 madison ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's (Dchester) Howard Co. Md	Nov 1 1920
20 UNDERTAKER Henry Lutz	ADDRESS 1007 N. Bond

47688 HEALTH DEPARTMENT—CITY OF BALTIMORE 47688

CERTIFICATE OF DEATH.

64

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No.) Mercy Hospital ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. G. Bonde

(Residence in Baltimore: No. Washington Pl St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Married

6-DATE OF BIRTH, March 14, 1869
(Month) (Day) (Year)

7-AGE, 51 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Photographer
(b) General nature of industry, business, or establishment in which employed (or employer) Own

9-BIRTHPLACE, (State or Country), Denmark

PARENTS.

10-NAME OF FATHER, R. Bonde

11-BIRTHPLACE OF FATHER (State or Country), Denmark

12-MAIDEN NAME OF MOTHER Karen Hansd

13-BIRTHPLACE OF MOTHER (State or Country), Denmark.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. P. Hoffman

(Address) Denver Colo

15- OCT 31 1920

Filed ..... 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Melena (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. Fowler M. D.
(Coroner.)

Oct 31, 1920 (Address) 1437 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19...
Mt Auburn	
20-UNDERTAKER	ADDRESS
Washington D.C.	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D47689

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47689

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.; 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lindsay Dean

(a) RESIDENCE. No. 1123 Bolton St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Dean

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Custis Jaws

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Wilenna Kellum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M.T.H.

15 Filed OCT 31 1920 ROBERT S. BRADEN Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28, 1920

17 I HEREBY CERTIFY, That I attended deceased from August 5, 1920, to Oct. 28, 1920, that I last saw her alive on Oct. 28, 1920, and that death occurred, on the date stated above, at 9.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. J. Rigney, M. D.

10-29-20, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Oct 31 1920
20 UNDERTAKER Mrs Robt Elliott	ADDRESS 1725 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1047690 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047690

CERTIFICATE OF DEATH.

REGISTERED No. C 172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 N Stricker ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha A Huber

(Residence in Baltimore: No. 109 N Stricker St.; 84 yrs., 9 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, June (Month) 1 (Day), 1836 (Year)

7-AGE, 84 yrs. 9 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm Hawkins

11-BIRTHPLACE OF FATHER (State or Country), Mckeown

12-MAIDEN NAME OF MOTHER Elizabeth Ingerson

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Huber

(Address) 109 N Stricker St

15- OCT 31 1920 ROBERT B KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 8 1919, to Oct 29 1920, that I saw h[er] alive on Apl 15 1920, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Senility of age

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Oct 8 1919 Fracture of surgical neck of R. Femur (Duration) ....yrs. ....mos. ....ds.

(Signed) M. E. Smith M. D.

(Oct 29, 1920 (Address) 118 N Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Nov 1st, 1920

20-UNDERTAKER	ADDRESS
Geo Huber & Son	2503 Edmondson Ave

(Over)

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047691

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047691

64

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 London Ave ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah P. Tucker

(a) RESIDENCE. No. 100 London Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 87 yrs. 10 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gustavus Tuckes

6 DATE OF BIRTH (month, day, and year): Dec. 10-1832

7 AGE — Years: 87 — Months: 10 — Days: 19 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 30

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Gustavus Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? ?

14 Informant: Mrs. B. Mills

(Address): 100 London Ave

15 Filed OCT 31 1920 ROBERT I. [illegible] Registrar

Chief Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 29 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1920, to Oct 29, 1920, that I last saw her alive on Oct 28, 1920, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Senile Arteriosclerosis

Acute (duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. K. Skilling, M. D.

10-29, 1920 (Address) 4107 Liberty Heights

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London PK

DATE OF BURIAL: 11/1 19[illegible]

20 UNDERTAKER: J. F. McCurley

ADDRESS: 130 S. Fr[illegible]

S516

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047692

HEALTH DEPARTMENT—CITY OF BALTIMORE

047692

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balti. Eye Ear + Throat Hospital

CITY OF BALTIMORE: (No. ..... St.: 17 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harvey Kelley

(a) RESIDENCE. No. Rock Hall Md St., Ward. Rock Hall Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Kelley

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rock Hall Md

PARENTS

10 NAME OF FATHER Charles Kelley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rock Hall Md

12 MAIDEN NAME OF MOTHER Crockett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rock Hall Md

14 Informant J Lewis (Address) 1411 E Balto St

15 Filed OCT 31 1920, 19 ROBERT E. LEE... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/30 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 —, 1920, to Oct 30, 1920, that I last saw him alive on Oct 30 —, 1920, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Septic Hemorrhagic of Fabial Sinus. General Septicemia —

— (duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Ch. Suf. Ot. Media —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home — Sept 16-1920

Did an operation precede death? yes Date of — Sept 28-1920 Oct 19-1920

Was there an autopsy? No Positive blood culture hemolytic streptococcus

What test confirmed diagnosis? Streptococcus

(Signed) Jesse W Downes, Jr. M. D.

, 19 (Address) 529 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rock Hall Md

DATE OF BURIAL 11/1 1920

20 UNDERTAKER Jack Lewis

ADDRESS 1441 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D47693

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47693

CERTIFICATE OF DEATH.

X 78

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. 10 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Vera Dunn

(Residence in Baltimore: No. 712 Aisquith St.; ....yrs., 1 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Unknown ..... (Month) ..... (Day) 1890 (Year)

7-AGE.	If LESS than 1 day,
30 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Louis

(Address) 1411 E Baltimore St

15-

OCT 31 1920 ROBERT B KRAUTER

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 29th. 1920, to Oct. 30 1920, that I saw her alive on Oct 30th. 1920, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Bacterial Endocarditis

..... (Duration).....yrs.....mos. 21 ds.

CONTRIBUTORY..... (Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....B. Sachs.....M. D.

10/31, 192.1 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Russia

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Mt Carmel	10/31, 1920

20-UNDERTAKER	ADDRESS
Jack Louis	1411 E Balt

Please write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

047694 HEALTH DEPARTMENT—CITY OF BALTIMORE 047694

CERTIFICATE OF DEATH.

REGISTERED NO. C 19

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 N Pine ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertie Engel

(Residence in Baltimore: No. 2507 McCulloh Street St.; 24 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, ... November ....., 1896
(Month) (Day) (Year)

7-AGE, 24 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Morris Perlis

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Goldie —

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hyman Engel

(Address) 701 N Gilmor St

15- OCT 31 1920 ROBERT B KRAUTER

Filed ....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... October ..... 30 ....., 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1920, to October 30 1920, that I saw h er alive on October 30 1920, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

..... Hemorrhage Pulmonary .....
..... Tuberculosis .....
..... (Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) ..... Acute Exacerbation of .....
..... (Duration)....yrs....mos....ds.

(Signed) ..... M. D.
....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Rehrer McConnell — DATE OF BURIAL, 10-31, 1920

20-UNDERTAKER Jack Levi — ADDRESS 1411 Bank St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D47695 HEALTH DEPARTMENT—CITY OF BALTIMORE D47695

CERTIFICATE OF DEATH. 40

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 Washington ST.: W WARD)

2-FULL NAME Esther Levy

(a) RESIDENCE. No. 1834 E. Pratt ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris B. Levy.

6 DATE OF BIRTH (month, day, and year) Sept. 15, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	6		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work N.W. 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Morris Herman
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER ?
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Lewis 141 E Baltimore St

15 Filed OCT 31 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-30 1920

17 I HEREBY CERTIFY, That I attended deceased from August 7, 1920, to Oct. 30, 1920 that I last saw h[illegible] alive on Oct. 30, 1920, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach with metastasis to liver 4
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Israel J. Trudy Co M. D.

Oct 30 1920 (Address) 1807 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew [illegible]	10/31 1920
20 UNDERTAKER Jack Lewis	ADDRESS 141 E Balt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1047696

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047696

CERTIFICATE OF DEATH.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 York Road ST.; 9 WARD)

2-FULL NAME Mary Ann Ludge

(Residence in Baltimore: No. 422 York Road St.; 74 yrs. 10 mos. 16 ds.)

Removed to 119 Hawthorn Rd. Roland Park

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Dec. (Month) 13 (Day), 1845 (Year)

7-AGE, 74 yrs. 10 mos. 16 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, James Logue

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER not Known

13-BIRTHPLACE OF MOTHER (State or Country), not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. K. C. Sefton

(Address) 119 Hawthorn Road

15-

Filed OCT 31 1920, 191.... ROBERT B. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 25 1920, to Oct. 29 1920, that I saw her alive on Oct 29 1920, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Arteriosclerosis

Convulsion at term ?

Death ?

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) General Senile Arteriosclerosis

(Duration) 10 yrs. + mos. ds.

(Signed) M. F. Fiske M. D.

Oct. 29, 1920. (Address) 422 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge Cem	11— 1—, 1920
20-UNDERTAKER Henry M. Jenkins & Son Co	ADDRESS Orchard and McCulloh

Be sure to write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047697 HEALTH DEPARTMENT—CITY OF BALTIMORE 047697

CERTIFICATE OF DEATH.

9V

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ellamont & Frest ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Sullivan

(a) RESIDENCE. NO. Ellamont & Frest ST., 70 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M. Sullivan

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Mason

(b) General nature of industry, business, or establishment in which employed (or employer) 075

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant N. E. Hogarth

(Address) 3314 Thames Ave

15 Filed OCT 31 1920 ROBERT E. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 19 20

17 I HEREBY CERTIFY, That I attended deceased from Oct 28 19 20, to Oct 29, 19 20,

that I last saw h[illegible] alive on Oct 28, 19 20,

and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) W. A Knull, M. D.

10/31, 19 20 (Address) Irvington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	11/2/20 19
20 UNDERTAKER	ADDRESS
C. H. Dill	3109 Frederick Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047698

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047698

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Media Lawson

(a) RESIDENCE. No. 228 W. Biddle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Solomon Lawson

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 26 Years Months Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer): Servant X

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Northumberland Co Va

PARENTS

10 NAME OF FATHER: Amos Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Martha Furr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Solomon Lawson
(Address) 228 W. Biddle St

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30th 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 10th 1920, to Oct 30th 1920,

that I last saw h-er alive on Oct 30th, 1920,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation of Heart

(duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary): Acute Parenchymal Nephritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry F. Brown M. D.

10/30 1920 (Address) 501 Freeman st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rudesville Va	Oct 31 1920
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1047699 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047699

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1929 h White St. 20 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa A. Lindsay

(Residence in Baltimore: No. 1929 h White St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov 15, 1870 (Month) (Day) (Year)

7-AGE, 50 yrs. 11 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)

037

9-BIRTHPLACE, (State or Country), Richmond va

PARENTS.

10-NAME OF FATHER, James Bradford

11-BIRTHPLACE OF FATHER (State or Country), va.

12-MAIDEN NAME OF MOTHER Louisa Brown

13-BIRTHPLACE OF MOTHER (State or Country), va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Noah A. Lindsay

(Address) 1929 White St

15-

Filed OCT 31 1920, 191 ROBERT F. HEATH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 27, 1920 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 13 1920, to Oct 26 1920, that I saw h d alive on Oct 26 1920, and that death occurred, on the date stated above, at 8 25 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(Duration) yrs. 6 mos. ds.

(Signed) W. P. Hughes M. D.

Oct 29, 1920 (Address) 1413 E Hoffman St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Oct 27, 1920

20-UNDERTAKER George H Holland — ADDRESS 1631 Linwood Ave

IMPORTANT. See instructions on back of certificate. Physicians are required to report in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

D47700 Sarah E. Dempsey D47700

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 6 29

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2732 E Balto. St.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. Dupsey

(Residence in Baltimore: No. 2732 E. Balto St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, July 29, 1833 (Month) (Day) (Year)

7-AGE, 87 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Woman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Adam Rae

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Eliza Murray

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David H. Dempsey

(Address) 2732 E. Baltimore St

15-

Filed OCT 31 1920, 191.....

ROBERT F. BEAUTE Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 29, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. H. Bentley (Coroner) M. D.

10:50 A.M. 12 (Address) 7 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Nov. 1, 1920

20-UNDERTAKER George J. Smith — ADDRESS South Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D47701 HEALTH DEPARTMENT—CITY OF BALTIMORE 47701

CERTIFICATE OF DEATH.

REGISTERED NO. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 140 W Mc Culloh St.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bruce Goldman

(Residence in Baltimore: No. 140 W Mc Culloh St.: ....yrs.,.... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, August, 1919
(Month) (Day) (Year)

7-AGE, 1 yrs. 7 mos. .... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country), Balto, Md

PARENTS.

10-NAME OF FATHER, John Goldman

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER Lucretia Condry

13-BIRTHPLACE OF MOTHER (State or Country), Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Goldman

(Address) 140 W Mc Culloh

15- OCT 31 1920 ROBERT P. KRAUTER
Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 27th, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22nd 1920, to Oct 27th 1920, that I saw h[illegible] alive on Oct 26th 1920, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) .... yrs. .... mos. 5 ds.

CONTRIBUTORY (Secondary) Probably from a bowel infection

(Duration) .... yrs. .... mos. 5 ds.

(Signed) A. [illegible] Ellis M. D.

1031, 1920 (Address) 927 Mad. Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cem	Oct 31, 1920
20-UNDERTAKER John A. Bishop Sr	ADDRESS Druid Hill

Burial Permit

Remarks The first involvement was a Diarrhoea
Enteritis

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, 6 *yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Bks.

D47702 HEALTH DEPARTMENT—CITY OF BALTIMORE D47702

CERTIFICATE OF DEATH.

151

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 Harlem Ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Virginia Hultz

(Residence in Baltimore: No. 1611 Harlem Ave St.; ..... yrs. Life time mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Sept (Month) 5 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
✓ yrs. 1 mos. 25 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... child
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Carroll I. Waltz

11-BIRTHPLACE OF FATHER (State or Country), Carroll Co Md.

12-MAIDEN NAME OF MOTHER Margaret F. Frizzell

13-BIRTHPLACE OF MOTHER (State or Country), Carroll Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Carroll I. Waltz

(Address) 1611 Harlem Ave City

15- OCT 31 1920 ROBERT P. KRAUTER

Filed....., 191.... Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5 1920, to Oct 30 1920; that I saw h.. alive on Oct 20 1920; and that death occurred, on the date stated above, at 1.45 p. m.

The CAUSE OF DEATH* was as follows: See back

Premature birth. about 6½ mos.

(Duration) ✓ yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Insufficient Animation

(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) Geo E Shannon M. D.

Oct. 30, 1920 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Bethel Cemetery, Md	Oct 31, 1920
20-UNDERTAKER C. M. Shaw.	ADDRESS Hampden Md.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

47703 HEALTH DEPARTMENT—CITY OF BALTIMORE 47703

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 N. Fulton Ave ST. 15 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalie L. B.

(a) RESIDENCE. No. 1824 N Fulton Av ST. ..... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 2— 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Casper Loy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wildman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John L. B. (Address) 1824 N Fulton Ave

15 Filed NOV 1 1920 ROBERT E. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1920, to Oct. 29, 1920, that I last saw her alive on Oct. 29, 1920, and that death occurred, on the date stated above, at 7-15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) 4 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral compression

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Gen. Paralysis.

(Signed) C. H. Smith, M. D.

Oct 31 1920 (Address) 3429 Chestnut Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 2 1920
20 UNDERTAKER	ADDRESS
Wm. Sloan & Son	North Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

47704 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓47704

120

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2441 Druid Hill Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry L Becker

(a) RESIDENCE. No. 2441 Druid Hill ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jos E. Becker

6 DATE OF BIRTH (month, day, and year) Jan 31-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jos E Becker (Address) 2441 Druid Hill Ave

15 Filed NOV 1 - 1920, 19... ROBERT P. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1920, to Oct 29, 1920, that I last saw h[illegible] alive on Oct 29, 1920, and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Left Sided)

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination + history

(Signed) Joseph H Hunter, M. D.

, 19 (Address) 1003 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 1 19
20 UNDERTAKER W E Ecclestone & Son	ADDRESS Forest

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1947705 HEALTH DEPARTMENT—CITY OF BALTIMORE 1947705

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH City Hospitals, Bay view. REGISTERED NO.

CITY OF BALTIMORE: (No. ..... St.: 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthew Riley

(a) RESIDENCE. No. Alms House. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Irelan, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of Industry, business, or establishment in which employed (or employer) General manual labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER ?—

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Bay view Hosp. Records.
(Address)

15 Filed NOV 1 - 1920 ..... Registrar

ROBERT J. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1920, to Oct 30, 1920, that I last saw him alive on Oct 30, 1920, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral haemorrhage, localization not made out

a few hours
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & chronic diffuse nephritis. Hypertension.
(duration) 1 yrs. 5 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? will be in A.M. 11-1-20

What test confirmed diagnosis?

(Signed) Lawrence Ed ..... M. D.

..... 19 (Address) Bay view Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenly Cem.	11/1/20.
20 UNDERTAKER	ADDRESS
Gas Dryden & Son	1000 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047706

HEALTH DEPARTMENT—CITY OF BALTIMORE

047706

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 N. Chapel ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Thomas

(a) RESIDENCE. No. 127 N. Chapel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 24, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Minnie Canty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Carolina

14 Informant William Thomas
(Address) 127 N. Chapel

15 Filed NOV 1 - 1920, 19 ROBERT P. LAMDIN Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1920

17 I HEREBY CERTIFY, That I attended deceased from 10-30-, 1920, to 10-30-, 1920, that I last saw h[illegible] alive on 10-30-, 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Bronchs-Pneumonia

OVER

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. H. Cargill, M. D.

10-30, 1920 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Nov 1 1920

20 UNDERTAKER Milton Davis ADDRESS 413 N Eden St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infection prior to pneumonia! Premature baby.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47707

HEALTH DEPARTMENT—CITY OF BALTIMORE

150 D47707

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 705 W. West St. ST.: 22 WARD)

2-FULL NAME Edward Becker.

(a) RESIDENCE. No. 705 W. West ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/31/20.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm. Becker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Grace E. Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md.

14 Informant Wm Becker
(Address) 705 W. West St

15 Filed 19 SOBERT B KLAUER Registrar
NOV 1 - 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/31 1920

17

I HEREBY CERTIFY, That I attended deceased from ....., 19....., to Oct. 31, 1920,

that I last saw him alive on Oct. 31, 1920,

and that death occurred, on the date stated above, at 8.15 a.m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

Blue baby.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. Edw Smith M. D.

Address) 910 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Nov 19
20 UNDERTAKER	ADDRESS
Wm Cook & Bro	Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement—OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dr Ruzicka
800 N. Patterson Park

D47708

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D47708

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 728 Mura ST.; 10 WARD)

2-FULL NAME Mary E. Dooster

(a) RESIDENCE. No. 728 Mura ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced (HUSBAND) of (or) WIFE of: John F. Dooster

6 DATE OF BIRTH (month, day, and year): Aug 18 - 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Charles H. Dillard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mass

12 MAIDEN NAME OF MOTHER: Elizabeth Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md

14 Informant: John F. Dooster
(Address) 728 Mura St

15 NOV 1 - 1920 19.. ROBERT B. KRAUTER Registrar

Burial Permit Oleek

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1920 to Oct 30, 1920

that I last saw her alive on Oct 30, 1920

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Mitral Regurgitation
Nephritis, Hypertension

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis? Findings

(Signed) M Ruzicka M. D.

10-31 19 20 (Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL: Nov 2 20

20 UNDERTAKER: William Cook

ADDRESS: 501 E North Ave

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47709

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D47709

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 W Lexington ST.; 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Dickman

(a) RESIDENCE. No. 808 W Lexington ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo J Dickman

6 DATE OF BIRTH (month, day, and year) Aug 15 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	~~11~~ 2	20	

8 OCCUPATION OF DEATH

(a) Trade, profession or particular kind of work ✓ 000

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife.

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wright.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) dont Know

14 Informant Rob E Dickman

(Address) 647 W Lexington

15 Filed NOV 1 1920 ROBERT J KRAUTH Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15. 1920. to Oct 30. 1920. that I last saw her alive on Oct 27. 1920. and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

(duration) yrs. mos. 15. ds.

CONTRIBUTORY (Secondary) Old age.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M C Friedmann M.D. M. D.

19 (Address) 687 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 1/ 1920
20 UNDERTAKER Wm Cook	ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Stock—6-9-19—H. P. Co.—1000 Pks.

D47710

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D47710

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 702 E Preston (St.:) 9 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Slatterback

(a) RESIDENCE. (No.) 702 E. Preston St (St.:) (Ward.)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 14/ 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) millersburg Pa.

PARENTS

10 NAME OF FATHER Joseph Wingard

11 BIRTHPLACE OF FATHER (city or town) (State or country) millersburg Pa.

12 MAIDEN NAME OF MOTHER Soana McPatt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) millersburg Pa

14 Informant Jenner Stoner
(Address) 702 E Preston St

15 Filed NOV 1 1920 Registrar ROBERT E LAPPE

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1920, to Oct 30, 1920, that I last saw h[er] alive on Oct 29, 1920, and that death occurred, on the date stated above, at 4-30 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm Pearce, M. D.

Oct 31, 1920 (Address) 702 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
(Oak Hill) millersburg Pa	Nov 2/20 19
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Mall

NOTE.—WRITE PLAINLY, WITH UNFADING INK.—THIS CERTIFICATE IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47711

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47711

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No.) 543 Monroe ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorenzo Thomas

(a) RESIDENCE. NO. 543 Monroe ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eddie Thomas

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dealer in Used Coal

(b) General nature of industry, business, or establishment in which employed (or employer) Selling Used Coal

(c) Name of employer Works for himself

9 BIRTHPLACE (city or town) (State or country) Calvert Co, Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Eddie Thomas

(Address) 543 Monroe St

15 Filed NOV 1 - 1920 ROBERT N. LEAUTE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 27 1920 to Oct 29 1920 that I last saw h.. alive on Oct 29 1920 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Phthisis

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Visiting relatives

Did an operation precede death? No Date of

Was there an autopsy? .....

What test confirmed diagnosis? Physical Examination

(Signed) D. Garland Thomas M. D.

Oct 30 1920 (Address) 1534 E. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 1 1920
20 UNDERTAKER	ADDRESS
Jos. A. Tradum	142 Uttie St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047712 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047712

CERTIFICATE OF DEATH. 37

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital. ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles C. Kraft.

(a) RESIDENCE. No. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Piano-tuner 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Charles Kraft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records, (Address) New City Hospital.

15 NOV 1 - 1920 ROBERT J KRAMER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25, 1920

17 I HEREBY CERTIFY, That I attended deceased from February 16, 1920, to October 25, 1920, that I last saw him alive on October 25, 1920, and that death occurred, on the date stated above, at 10:45 P.m.

The CAUSE OF DEATH* was as follows:

Progressive central muscular atrophy.

(duration) 30 yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Wassermann.

(Signed) V. B. Newman. M. D.

10/25/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF [redacted], CREMATION [redacted]	DATE OF BURIAL
Bay View Hospital	10-30-1920
20 UNDERTAKER J. B. Hunter	ADDRESS BVH

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047713

HEALTH DEPARTMENT—CITY OF BALTIMORE

047713

28-091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal T. B. Hospital St.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna Stabler.

(a) RESIDENCE. No. 628 Sixth St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) WIFE of Widow of John J. Stabler

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Undergraduate nurse. 048

(b) General nature of industry, business, or establishment in which employed (or employer) Tuberculosis Serv.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER John Davis.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Annie Fister

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant Mother Municipal T. B. Hospital
(Address) 628 S. 6th St.

15 FILED NOV 1 - 1920 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1920, to Octo 28, 1920, that I last saw her alive on October 28, 1920, and that death occurred, on the date stated above, at 755 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary) Hemorrhagic-pneumonia

(duration) yrs. 1 mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum

(Signed) L. J. Bayley, M. D.

, 19 (Address) Municipal Tuberculosis Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Nov. 1 1920
20 UNDERTAKER Lilly and Zeile	ADDRESS 403 S. Mo...

CAUSE OF DEATH to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47714 D 47714 104

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2708 Elliot St ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Theresa Lubinsky

(Residence in Baltimore: No. 2708 Elliot St St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	W	S

6-DATE OF BIRTH, Jan 23, 1920 (Month) (Day) (Year)

7-AGE, ... yrs. 9 mos. 7 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Walter Lubinsky

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Theresa Madinsky

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Lubinsky

(Address) 2708 Elliott St

15-

Filed NOV 1 1920 191.. ROBERT B KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 31, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1920, to Oct 30 1920, that I saw her alive on Oct 30 1920, and that death occurred, on the date stated above, at 12:30 M.

The CAUSE OF DEATH* was as follows:

Acute gastro Enteritis

Acute

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) L. J. Kaplinsky M. D.

Oct 31, 1920 (Address) 3035 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Stanislaus Cem	Nov 2, 1920
20-UNDERTAKER Stephen J Stalkowski	ADDRESS 1100 S Monument

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Piechocki

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47715

CERTIFICATE OF DEATH.

D 82 47715

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 S. Grove St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Piekhocki

(Residence in Baltimore: No. 814 S. Grove St

St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Mal

4-COLOR OR RACE, Whit

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept 18, 1873
(Month) (Day) (Year)

7-AGE, 46 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): U[illegible]

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, John Piechowski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER [illegible]

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Piechowski

(Address) 814 S. Grove

15- [illegible] KRAUTER

Filed NOV 1 1920, 191. Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 29, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 6 1920, to Oct 29 1920, that I saw h[illegible] alive on Oct 29 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Abscess of Spine abt 3

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (Metastatic?) abt 14

(Duration) yrs. mos. ds.

(Signed) Leo Kaluzsky M. D.

Oct 29, 1920 (Address) 3436 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Stanislaus Cem DATE OF BURIAL, Nov 2, 1920

20-UNDERTAKER Stephen J Frankowski ADDRESS [illegible] Monument

If LESS than 1 day, ...hrs. or....min.?

If DEATH OCCURRED IN A HOSPITAL OR INSTITUTION, give its NAME instead of street and number.

Entries must be made in plain black ink, so that all may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47716

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

152

D 47716

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 Oak ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME La Rue Adelbert Mc Clymont

(a) RESIDENCE. No. 2204 Oak ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day 19 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Arthur Mc Clymont

11 BIRTHPLACE OF FATHER (city or town) Oakridge
(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Sarah Gould

13 BIRTHPLACE OF MOTHER (city or town) E. Troy
(State or country) Pennsylvania

14 Informant Arthur Mc Clymont
(Address) 2204 Oak St

Filed NOV 1 - 1920 ROBERT R. [illegible]
Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 31 1920

17

I HEREBY CERTIFY, That I attended deceased from October 30, 1920, to October 31, 1920, that I last saw him alive on October 31, 1920, and that death occurred, on the date stated above, at 10:40 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. dn.

CONTRIBUTORY (Secondary) Congenital Atelectasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. H. Machen, M. D.

, 19 (Address) 4119 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sanford Delware	Nov 1 192
20 UNDERTAKER	ADDRESS
M. Gosson	8 W 37

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

d47717

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

152 d47717

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 W. Hughes ST. 22 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Stewart

(Residence in Baltimore: No. 14 W Hughes St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH October 28, 1920 (Month) (Day) (Year)

7-AGE, ...yrs....mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None (Baby)
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Dewey Stewart

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER Annie Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Stewart

(Address) 14 W Hughes st

15- Filed NOV 1 - 1920, 191.... ROBERT B KRAUTER Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 30, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 28 1920, to Oct 30 1920, that I saw him alive on Oct 30 1920, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Intra Cranial Hemorrhage

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Fracture comminution of Skull

(Duration) ....yrs....mos....ds.

(Signed) J H Bottes M. D.

Oct 30 1920 (Address) Emmorett Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn ct | DATE OF BURIAL, NOV 1, 1920

20-UNDERTAKER J. H. Brown & Son | ADDRESS 108 W Monto

Please print in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D47718

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D47718

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 Eutaw Place ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Frances Cooper

(a) RESIDENCE. No. 1421 Eutaw Place ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 9 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year) Jan 9 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: X None 000

(b) General nature of industry, business, or establishment in which employed (or employer): X

(c) Name of employer: X

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Hughlett Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Harriet Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. A. C. Sylvester
(Address): Thurmont Md.

15 Filed NOV 1 — 1920 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31st 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1919, to Oct 31st, 1920, that I last saw her alive on 31st, 1920, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Heart Disease — Mitral Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Asthmatic Attacks

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? X Date of X

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Chas. E. Sadtler, M. D.

. 19 (Address) 1421 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Nov 2 19
20 UNDERTAKER: Edwards & Sons Co.	ADDRESS: W. Fullola Orchard.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47719

CERTIFICATE OF DEATH.

28 D47719

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No. ..... ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Martha B. Carter

(Residence in Baltimore: No. 2108 N. Charles St. St.; 20 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~, (Write the word.) Widowed

6-DATE OF BIRTH, Jan. (Month) 11 (Day), 1853 (Year)

7-AGE, 67 yrs. 7 mos. 22 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... Home wife
(b) General nature of industry, business, or establishment in which employed (or employer) ... None

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Mr. Brook Boughton

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Miss Dunn

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. M. Richardson

(Address) Catonsville Md.

15- NOV 1 - 1920 ROBERT B KRAUTER
Filed ..., 191...
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 1st (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1920, to Nov. 1 1920, that I saw her alive on Nov 1 1920, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

..... (Duration) ... yrs. 1 mos. 22 ds.

CONTRIBUTORY (Secondary) The Peritonitis

..... (Duration) ... yrs. 1 mos. 22 ds.

(Signed) J. H. Sherman Carter M. D.

Nov. ..., 1920. (Address) Union Memorial Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ... yrs. 1 mos. 22 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 2108 N. Charles St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Nov. 2, 1920
20-UNDERTAKER	ADDRESS
Henry W Jenkins Sons Co	7th Fulton Orchard

Please write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47720

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15H D 47720

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 Linden Ave ST.: 11 WARD)

2-FULL NAME James Albert Gary

(a) RESIDENCE. No. 1200 Linden Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Lavinia C Gary

6 DATE OF BIRTH (month, day, and year) 1832-10-22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cotton Manf. 1645

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lucasville Conn.

PARENTS

10 NAME OF FATHER: James S. Gary

11 BIRTHPLACE OF FATHER (city or town) (State or country): Conn

12 MAIDEN NAME OF MOTHER: don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: E Stanley Gary.
(Address): Gardenville Md.

15 Filed NOV 1 - 1920 ROBERT S. KRAUTER Registrar
Registrar's Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1918, to Oct, 1920, that I last saw him alive on Oct 31 1920 and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema (duration) yr. mos. 1 ds.

CONTRIBUTORY (Secondary) Senility. Chronic Nephritis (duration) 10 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A Warren Buckler, M. D.

19 (Address) 806 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Nov. 2 1920
20 UNDERTAKER: Funeral Directors Co.	ADDRESS: Gulloh Orchard.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47721 HEALTH DEPARTMENT—CITY OF BALTIMORE D47721

CERTIFICATE OF DEATH.

92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3303 Eastern Ave ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustavis LeRoy Lawson

(a) RESIDENCE. NO. 3303 Eastern Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 23, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Maryland

PARENTS

10 NAME OF FATHER Gus Lawson Jr.

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen M. Phillips

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Maryland

14 Informant Gus Lawson Jr.
(Address) 3303 Eastern Ave

15 Filed NOV 1 - 1920 ROBERT B KRUTZEN (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1920, to Oct 30, 1920

that I last saw him alive on Oct 30, 1920,

and that death occurred, on the date stated above, at 10 40 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) Frank A. Hunt M. D.

.19 (Address) 3244 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Nov. 2 1920
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Fleet

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D47722

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47722

CERTIFICATE OF DEATH.

1-PLACE OF DEATH. CITY OF BALTIMORE (No. Bamp Cemetery Co ST.: 26 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME engnd E Schlatter

(Residence in Baltimore: No. Myrtle av Rosedale St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Divorced

6-DATE OF BIRTH, June 8, 1893. (Month) (Day) (Year)

7-AGE, 27 yrs. 3 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) 031

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, August Schlatter

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN ~~NAME~~ OF MOTHER Minnie Loos

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie Schlatter

(Address) Myrtle av

15- ROBERT B KRAUTER

NOV 1 - 1920, 19 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 28, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Electrocution

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Henry Lyon Oakley M. D.
(Coroner)

Oct 31, 1920 (Address) 1009 Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cemetery	Nov. 1, 1920
20-UNDERTAKER	ADDRESS
H. Vander & Son	710 Fleet St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

No 2620

D47723 HEALTH DEPARTMENT—CITY OF BALTIMORE D47723

CERTIFICATE OF DEATH.

1892

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 618 Penn ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kuneyonda Kubik

(Residence in Baltimore: No. 618 Penn St.; 31 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female.	White	Widow

6-DATE OF BIRTH, Unknown, (Month) ..... (Day), 1833 (Year)

7-AGE, 88 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) Housework

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Simon Drozga (Son.)

(Address) 520 S. Ann St.

15- NOV 1 - 1920 ROBERT B KRAUTER

Filed ....., 191 ..... Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 29th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest~~ autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Westphalen find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural Causes

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry Louis Lusky M. D.
(Coroner.)

Oct 29, 1920. (Address) 1700 N Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus. DATE OF BURIAL, Nov 2nd, 1920

20-UNDERTAKER M. F. Sudowski ADDRESS 705 S. Ann St.

Alivater

Spec. 6-9-19—H. P. Co.—1000 Bks.

D47724

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47724

CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alpha M. Altwater Jr.

(a) RESIDENCE. No. 3106 Garrison Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10th 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work school boy. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Alpha M. Altwater Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mollie Short

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant (Address) Alpha M. Altwater Sr 3106 Garrison ave

15 NOV 1 - 1920 ROBERT B. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 29 1920

17 I HEREBY CERTIFY, That I attended deceased from 10-20 . 1920 . to 10-28 . 1920.

that I last saw him alive on 10-29 . 1920.

and that death occurred, on the date stated above, at 4.25 P m.

The CAUSE OF DEATH* was as follows:

Ruptured appendix

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jack M Hundley M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Monument Cem	11/2/20
20 UNDERTAKER	ADDRESS
Geo. Schilling & Sons	1146 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Stmc.—6-9-19—H. P. Co.—1000 Bks.

D.47725

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47725

CERTIFICATE OF DEATH.

42

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2309 Maryland Av ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Adelaide Victoria Louise Barkley

(a) RESIDENCE. No. 2309 Maryland ST., 12 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ? mos. ? ds. How long in U. S., If of foreign birth? 79 yrs. 11 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John C. Barkley

6 DATE OF BIRTH (month, day, and year) Nov- 8-1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 00

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Mt Elizabeth Pennsylvania

PARENTS

10 NAME OF FATHER: James Millikin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Elizabeth Pennsylvania

12 MAIDEN NAME OF MOTHER: Laura Haldon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known not known

14 Informant: Mr. James M. Barkley - (son)

(Address): Windsor - Essex Co. New York.

15 Filed NOV 1 - 1920 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1st 1920

17 I HEREBY CERTIFY, That I attended deceased from May 1915. , 19 , to Nov 1st , 1920 .

that I last saw h alive on Oct 30 , 1920 .

and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteras with general metastasis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes - Type -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination. Clinical

(Signed) Edward J. McCarty, M. D.

11-1-1920 (Address) 817 W. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Nov. - 3 1920

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D.47726 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47726

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 Bradley ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lady Queen Guthrie

(a) RESIDENCE. No. 711 Bradley ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) October 27, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, 16 hrs. or min.
✓	✓	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None - Baby

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Jasper L. Guthrie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Middle Ser Co Virginia

12 MAIDEN NAME OF MOTHER Isabelle Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant

(Address)

15 Filed NOV 1 - 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 28 1920

17

I HEREBY CERTIFY, That I attended deceased from October 27, 1920, to October 28, 1920, that I last saw her alive on October 28th, 1920, and that death occurred, on the date stated above, at 6.00 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity (34 wks).

(duration) yrs. mos. 16 hrs.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J. Morris Slepe, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	OCT 30 1920 19
20 UNDERTAKER	ADDRESS

Commissioner of Health.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47727

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47727

91-143

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Biddle (mrs.)

(Residence in Baltimore: No. 518 N. Port St. St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov 27, 1882
(Month) (Day) (Year)

7-AGE, 38 yrs. 11 mos. 27 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework 137
(b) General nature of industry, business, or establishment in which employed (or employer)..... Poultry-worker

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thomas Finnerty

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Riley

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Coyne

(Address) 815 E. Chase St.

15- Filed NOV 1 - 1920, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 27 1920, to October 30 1920, that I saw her alive on October 29 1920, and that death occurred, on the date stated above, at 7:30 A.m.

The CAUSE OF DEATH* was as follows:

Carbuncle of Back

(Duration) about yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Broncho-pulmonia

(Duration) yrs. mos. 2 ds.

(Signed) W. E. Owens M. D.

Oct. 30, 1920 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. 4 ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 518 N. Port St.

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Nov. 2., 1920

20-UNDERTAKER Margaret E. Flynn ADDRESS 1422 Light St.

Important. See instructions on back of certificate. Accuracy in stating the exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47728 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47728

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3713 E Fayette St.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Wilhelmina Long

(a) RESIDENCE. No. 3713 E Fayette St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Long.

6 DATE OF BIRTH (month, day, and year) Jan 6-1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Vollerdt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Annie Kaiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Louis Long (Address) 3713 E Fayette

15 Filed Nov 1 1920 Robert P. Harrison Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 15, 1920, to Oct 31, 1920, that I last saw h.e alive on Oct 30, 1920, and that death occurred, on the date stated above, at 6.P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. E. Kinney, M. D.

Oct. 31, 1920 (Address) 1301 N Pat Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakdawn Cem	Nov 2 1920
20 UNDERTAKER	ADDRESS
John Henry & Co	208 Oakdawn

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.47729

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47729

8-091

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. S.E. cor 5th av & 14th St.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maud Susanna Floyd

(Residence in Baltimore: S.E. cor 5th av & 14th St.; ..... yrs., 1 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	W	S.

6-DATE OF BIRTH, Sept ..... (Month) ..... (Day) ....., 1920 (Year)

7-AGE,	If LESS than 1 day,
..... yrs. 1 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Elmer Floyd

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Lottie Kelly.

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...Elmer Floyd.....

(Address)...5 av & 14th St.....

15- Robert P. Harrison,
Filed ....., 191.....
Burial Permit Clerk.
Registrar.

OV 1 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 30, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ~~Oct 28~~ 1920, to Oct 30 1920, that I saw her alive on Oct 30 1920, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Int
Bronchial pneumonia
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation
..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Ked Harrison M. D.

Oct 31, 1920 (Address) 3035 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cem	Nov 2, 1920.
20-UNDERTAKER	ADDRESS
John Herwig & Co	2005 Orleans

important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D.47730 ✓D.47730

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28.010

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 Kelly Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Louisa Hooker

(Residence in Baltimore: No. Kelly Ave Int Washington St.; 4 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, November (Month), (Day), 1862 (Year)

7-AGE, 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Ind

PARENTS.

10-NAME OF FATHER, Robert Queen

11-BIRTHPLACE OF FATHER (State or Country), Prince Georges, Md

12-MAIDEN NAME OF MOTHER Mary A Fletcher

13-BIRTHPLACE OF MOTHER (State or Country), Prince George Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James A Johnson, Son

(Address) 821 George St.

15- NOV 1 - 1920 Robert P. Harrison, 191 Registrar.

Burial Permit Cl

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 (Month) 29 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 1919, to Oct 28th 1920, that I saw h-e alive on Oct 28 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis follow
ing attack of Influenza

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. H. Beeten M. D.

Oct 29, 1920 (Address) Int Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Int Auburn Cemetery	Nov 2nd, 1920
20-UNDERTAKER	ADDRESS
Chas G Bailey	Jefferson st

Important. See instructions on back of certificate.

D.47731 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47731

CERTIFICATE OF DEATH

28

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 221 S. Pulaski St. 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mrs Margaret Follmer

(Residence in Baltimore: No. 221 S Pulaski St.; 50 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: White | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: April (Month) 1 (Day), 1858 (Year)

7 AGE: 62 yrs. 7 mos. 29 ds. | If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At home 037

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: Hantsch

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Kurtz

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Follmer

(Address) 2218 Pulaski

15. NOV 1 - 1920, 191 Robert P. Harrison,

Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. (Month) 30th (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9, 1920, to Oct 29, 1920, that I saw her alive on Oct 29, 1920, and that death occurred, on the date stated above, at 8.00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 0 yrs. 5 mos. 0 ds

Contributory (SECONDARY) —

(Duration) ... yrs. ... mos. ... ds.

(Signed) S A Bolden M. D.

Nov 1 1920, (Address) 3 W Chase Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park | DATE OF BURIAL: Nov 2, 1920

20 UNDERTAKER: George L Schnebel | ADDRESS: W Saratoga

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Examination of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-2883
D. 47732

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 47732

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: E Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Parisis

(a) RESIDENCE. NO. 715 S Broadway St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? (illegible) yrs. (illegible) mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male.	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 6, 878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General natore of Indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece.

PARENTS

10 NAME OF FATHER George Parisis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Despina Parisis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant (illegible)
(Address) 715 Broadway

15 Filed NOV 1 - 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1920, to Oct. 30, 1920, that I last saw h.....alive on Oct 30, 1920, and that death occurred, on the date stated above, at 955a m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. E. Mason, M. D.

10/31, 1920 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincents Cem	11/2/ 1920
20 UNDERTAKER	ADDRESS
Chas. F. Evans & Son	118 N. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Effect of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47733 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47733

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 207 Aisquith St.: 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney Hall

(a) RESIDENCE. No. 207 Aisquith St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 114 yrs. mos. ds. How long in U. S., if of foreign birth? 114 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: colored | 5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1806

7 AGE — Years: 114 yrs | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: James Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Watsmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Mary White
(Address) 207 Aisquith

15 Filed NOV 1 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1920, to Oct 30, 1920, that I last saw h alive on Oct 29, 1920, and that death occurred, on the date stated above, at 12 15 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward Fisher M. D.

11-1 1920 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Lawn | DATE OF BURIAL: Nov 2 1920

20 UNDERTAKER: Wm. H. Chase & Son | ADDRESS: 1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47734

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47734

64

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 Laurens ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pardine Lecht

(a) RESIDENCE. No. 1212 Laurens. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? 80 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J Lecht.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Lecht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Caroline Glaser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Alice Leicht (Address) Germany

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1920, to Oct 31, 1920

that I last saw her alive on Oct 31, 1920.

and that death occurred, on the date stated above, at 8.00 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Vernon H. Carden, M. D.

11/1, 1920 (Address) 750 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge cem	Nov 3 1920
20 UNDERTAKER H. L. Tichnor & Sons	ADDRESS Walbrook

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47735 ✓ D.47735

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1028 N Payson ST.; 16 WARD)

2-FULL NAME Comfort G. Bowen

(a) RESIDENCE. No. 1028 N Payson ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 12 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Arthur Bowen

11 BIRTHPLACE OF FATHER (city or town) Calvert Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Julia Brown

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co
(State or country) Md

14 Informant Arthur Bowen
(Address) 1028 N Brown St

15 Filed NOV 1 - 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1920, to Nov 1st, 1920, that I last saw h[illegible] alive on Oct 31 1920, and that death occurred, on the date stated above, at 600 a m.

The CAUSE OF DEATH* was as follows:

Colitis - Acute.

(duration) ✓ yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Intussusception

(duration) ✓ yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Consultation Dr Plummer.

(Signed) Geo L Shannon M. D.

11/1, 1920 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bowen Home Cemetery Calvert Co Md	Nov 2 1920
20 UNDERTAKER John P Denny	ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

~~3946~~ D.47736

HEALTH DEPARTMENT—CITY OF BALTIMORE D.47736

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.; 9 WARD)

2-FULL NAME Harry Bryan.

(a) RESIDENCE. No. 1526 Homestead St. Baltimore Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 2. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6 7	2 8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Leroy Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Helen Ritter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant
(Address)

15 Filed 19

Robert P. Harrison, Registrar
Burial Permit Clerk.

NOV 1 - 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 192 0

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1920, to Oct 30, 1920, that I last saw him alive on Oct 30, 1920, and that death occurred, on the date stated above, at 9:00 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) James C. Fox, Jr. M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 2 1920
20 UNDERTAKER John F. Kenny	ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

047737

CERTIFICATE OF DEATH.

91-089047737

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 Bradford ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin J. Fuchs

(Residence in Baltimore: No. 1629 Bradford St.: 74 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Sept (Month) 28 (Day), 1920 (Year)

7-AGE. ....yrs. 1 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph Fuchs

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Marie Hoffman

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Joseph Fuchs

(Address) 1629 N. Bradford St

15- NOV 2 - 1920 ROBERT I KRAUTER

Filed....., 191.... Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 1 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct 28 1920, to Nov. 1 1920, that I saw him alive on Nov. 1 1920, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) ....yrs. ....mos. 7 ds.

(Signed) Kent Fisher M. D.

Nov 1, 1920 (Address) 1823 N. Wash St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL, Nov 3, 1920.

20-UNDERTAKER Henry Storck Sons

ADDRESS 1301 E. Eager St.

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047738 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047738

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7. E. Biddle ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James C. Spence

(a) RESIDENCE, No. 7 E. Biddle St, ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. 10 mos. ds. How long in U. S., If of foreign birth? 55 yrs. 6 mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriet C Spence

6 DATE OF BIRTH (month, day, and year) Jan. 16. 1832

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
88	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired $00

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Edenburgh (State or country) Scotland

PARENTS

10 NAME OF FATHER James C. Spence

11 BIRTHPLACE OF FATHER (city or town) Edenburgh (State or country) Scotland.

12 MAIDEN NAME OF MOTHER Harriet C Reid

13 BIRTHPLACE OF MOTHER (city or town) Norfolk (State or country) Virginia

14 Informant Miss Lottie C. Spence
(Address) No 7 E. Biddle St

15 NOV 2 - 1920 ROBERT F. [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1920, to Oct 31st, 1920, that I last saw him alive on Oct 31st, 1920, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows: Arterio Sclerosis: Uraemia

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hem

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Course of Disease

(Signed) C B Gamble, M. D.

19 (Address) 24 N Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 2 1920
20 UNDERTAKER	ADDRESS
John B. Spence	1325 N. Caroline St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D47739

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47739

CERTIFICATE OF DEATH.

175-001

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. En route to Mercy Hospital ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aaron Thomas.(C)

(Residence in Baltimore: No. 1014 Leadenhall St. 50 St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored	Married.

6-DATE OF BIRTH, ..Do not know.., / (Month) (Day) (Year)

7-AGE, 69 yrs. ---- mos. ---- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Charles Co. Md.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Naomi Thomas.(C) daughter.

(Address) 1014 Leadenhall St.

15- Filed NOV 2 - 1920 191.... ROBERT B KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 29th. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the Skull.
Accidentally struck and run over by Automobile (License #87229)
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....
(Duration).....yrs.....mos.....ds.

(Signed) Otto C. Reinhardt M. D. (Coroner)

Nov. 1 191.. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?..... Hanover & Church St.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, U S National Ct. DATE OF BURIAL, Nov. 2, 1920

20-UNDERTAKER I. L. Brown and Son ADDRESS 1019 W. Monty St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

1047740 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047740

64

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Locust Ave & Oak St.; Overlea WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Ardin Goss

(Residence in Baltimore: No. Locust Ave & Oak St. Overlea St.; 64 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Aug (Month) 20 (Day) 1854 (Year)

7-AGE, 66 yrs. 2 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home

9-BIRTHPLACE, (State or Country) Balto Md.

PARENTS.

10-NAME OF FATHER David Ardin

11-BIRTHPLACE OF FATHER (State or Country) Balto. Md.

12-MAIDEN NAME OF MOTHER Clara Stewart

13-BIRTHPLACE OF MOTHER (State or Country) Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs A. Winkam

(Address) Overlea Md.

15 NOV 2 – 1920 ROBERT E KRAUTER

Filed....., 191.... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 1 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1920, to Nov 1 1920, that I saw her alive on Sept 30 1920, and that death occurred, on the date stated above, at 1.55 a. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis and hypertension (Duration) yrs. mos. ds.

(Signed) A. L. McKinnon M. D.

11/2/, 1920 (Address) Rosedale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Nov. 3, 1920
20-UNDERTAKER	ADDRESS
Fredk Lassahn Sons	Fullerton Md.

Cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D47741 HEALTH DEPARTMENT—CITY OF BALTIMORE D47741

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 3808 Rochester Rd ST.; 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William T. Undefined

(Residence in Baltimore: No. 3808 Rochester St.; 32 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M.	W.	Married

6-DATE OF BIRTH, Feb. (Month) 8 (Day), 1840 (Year)

7-AGE,	If LESS than 1 day,
70 yrs. 9 mos. ... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Undefined.

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Libia Ann Thoyer

13-BIRTHPLACE OF MOTHER (State or Country), Balto. md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev. W. B. Undefined

(Address) 3820 Barrington Rd

15. NOV 2 - 1920 Filed....., 191.... ROBERT E LEAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 1 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1918, to Nov 1 1920, that I saw him alive on Nov 1 1920, and that death occurred, on the date stated above, at 4.15 m.

The CAUSE OF DEATH* was as follows:

a Edema of Lungs

.....

.....

..... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) Wm. T. Undefined M. D.

11-2, 1920 (Address) 541 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Druid Ridge	Nov. 4, 1920

20-UNDERTAKER	ADDRESS
George F. Smith	1060 W. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

2047742 HEALTH DEPARTMENT—CITY OF BALTIMORE 2047742

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 7 N. Monroe. ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Upton Wade

(Residence in Baltimore: No. 7 N. Monroe. St.; 40 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, February (Month) 20 (Day), 1867 (Year)

7-AGE, 53 yrs. 8 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman D.B.
(b) General nature of industry, business, or estsblishment in which employed (or employer): wood-working

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Wade.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Rebecca Kinsey

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Thersa Wade (wife)

(Address) 7. N. Monroe St.

15- NOV 2 - 1920 ROBERT B KRAUTER

Filed....., 191.... Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 31 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from September 24 1920, to October 31 1920, that I saw him alive on October 22 1920, and that death occurred, on the date stated above, at 4.40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) none

(Duration) — yrs. — mos. — ds.

(Signed) Chester Ruland, M. D.

11-1, 1920 (Address) 2532 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mount Olivet Cemetery	Nov. 4, 1920
20-UNDERTAKER George A Smith	ADDRESS 2000 W. Fayette st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1147743 HEALTH DEPARTMENT—CITY OF BALTIMORE 1147743

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2218 Fleet St ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Felix Spinek

(a) RESIDENCE. NO. 2218 Fleet ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maryanna Spinek

6 DATE OF BIRTH (month, day, and year) May 10 71

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor O H O

(b) General nature of industry, business, or establishment in which employed (or employer) Tin Deco co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Tomas Spinek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Suzanne Fabinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Maryanna Spinek

(Address) 2218 Fleet St

ROBERT P. BEAUTER

15 NOV 2 - 1920 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1920, to Oct 31, 1920, that I last saw him alive on Oct 31, 1920, and that death occurred, on the date stated above, at 8 30 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis (Left side)

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. C. Grady, M. D.

19 (Address) 143 E Eager.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov 3 1920

20 UNDERTAKER	ADDRESS
John L. Weber	1803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47744 HEALTH DEPARTMENT—CITY OF BALTIMORE D47744

37

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Vogelman

(a) RESIDENCE. No. 607 Otterbein ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 1 mos. 24 ds. How long in U. S., if of foreign birth? 37 yrs. 1 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Vogelman

6 DATE OF BIRTH (month, day, and year) Sept 7-1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	..	1	24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER David Dawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bay View Hosp records
(Address)

15 Filed NOV 2 - 1920 ROBERT P. KRAUTH Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1920, to Nov 1, 1920, that I last saw her alive on Sept 31, 1920, and that death occurred, on the date stated above, at 7:30 P.m.

The CAUSE OF DEATH* was as follows:

Tabo - Paresis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Serological tests

(Signed) Dr. S. C. Medairy M. D.

. 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	11/3 1920
20 UNDERTAKER	ADDRESS
J. F. McCurley	130 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

L47745 — HEALTH DEPARTMENT—CITY OF BALTIMORE — L47745

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital — 175-001 — REGISTERED NO. C.

CITY OF BALTIMORE (No. ~~1990 Glover St.~~ WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank J Mechlinski

(Residence in Baltimore: No. 809 S Glover St — St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... May (Month) 15 (Day), 1911 (Year)

7-AGE, 9 yrs. 7 mos. ds. — If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Fr. Mechlinski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Maggie Mbinowicz

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Mechlinski

(Address) 809 S Glover St

15- NOV 2 - 1920 ROBERT B KRAUTER

Filed....., 191..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Oct (Month) 30 (Day), 191.. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest~~ autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~inquest~~ autopsy (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Killed by Train

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Geo. Gehr (Coroner.) M. D.

11/2, 1911 (Address) 1200 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Stans Stans Cem	Nov 2, 1920
20-UNDERTAKER Stephen J Fackenthal	ADDRESS 1001 Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1047746 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 1047746

CERTIFICATE OF DEATH.

REGISTERED NO. C 169

1-PLACE OF DEATH Foot of Caroline St

CITY OF BALTIMORE (No. 849 S Dallas St ST.: D WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Rostkowski

(Residence in Baltimore: No. 849 S Dallas St St.: yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Jan (Month) 16 (Day), 1914 (Year)

7-AGE, 5 yrs. 8 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Alex Rostkowski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Anna Kapucinska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alex Rostkowski

(Address) 849 S Dallas St

15- Filed NOV 2 - 1920, 191.... ROBERT F KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 31 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

Signed Harry P Quigley (Coroner) M. D.

Nov 4 1920, 191.... (Address) 1500 Aliceanna St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Nov 2 1920
20-UNDERTAKER William F Kirkowski	ADDRESS 1618 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

1047747 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047747

CERTIFICATE OF DEATH.

REGISTERED NO. C 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 N. Eden St ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bailey Levin

(Residence in Baltimore: No. 29 N. Eden St St.; 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day) 1 (Year)

7-AGE, 73 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Baltimore St

15- NOV 2 - 1920 ROBERT B KRAUTER

Filed ....., 191.... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 2nd, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 5, 1920, to Nov 1st 1920, that I saw her alive on Nov 1st 1920, and that death occurred, on the date stated above, at 2:30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas
& common bile duct
Chronic Cholecystitis

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. Blevens M. D.

Nov 2, 1920. (Address) The Walbert

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mosh Road — DATE OF BURIAL, Nov 4, 1920

20-UNDERTAKER, Jack Lewis — ADDRESS 1411 Eastaltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047748 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047748

CERTIFICATE OF DEATH.

REGISTERED NO. 172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3616 Forest Park Av. ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua Thomas

(a) RESIDENCE. No. 3616 Forest Park ST., 15 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Indiana Thomas

6 DATE OF BIRTH (month, day, and year) December 27-1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	10	5	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Retired from

(b) General nature of industry, business, or establishment in which employed (or employer) Window shade

(c) Name of employer Industry.

9 BIRTHPLACE (city or town) Alexandria
(State or country) Virginia

PARENTS

10 NAME OF FATHER Benjamin Thomas

11 BIRTHPLACE OF FATHER (city or town) Wales
(State or country) Switland

12 MAIDEN NAME OF MOTHER Jane George

13 BIRTHPLACE OF MOTHER (city or town) not known
(State or country) U. S. a.

14 Informant Mr Geo. E. Claylor (Son-in-law)
(Address) 3616 Forest Park Ave

15 NOV 2 - 1920 ROBERT B. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1 1920

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1920, to Nov 1 5, 1920, that I last saw h alive on Nov 1 5, 1920, and that death occurred, on the date stated above, at 11 P .m.

The CAUSE OF DEATH* was as follows:

Hypostatic Congestion of Lungs.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Fracture of F. femur

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Auscultation

(Signed) A. C. Simril, M. D.

(Address) 4804 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Alexandria-Va. DATE OF BURIAL Nov. 3/ 1920

20 UNDERTAKER STEUART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

1047749 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047749

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital, Bay St. 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Wills.

(a) RESIDENCE. NO. 1019 Jenkins alley ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) 1855 Jan. 25

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber Dealer.

(c) Name of employer Geo. E. Waters & Co.

9 BIRTHPLACE (city or town) (State or country) Cumberland. Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Miss Lena R. Mills (daughter) (Address) 220 W. Biddle St.

15 NOV 2 - 1920 ROBERT B. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31, 1920

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1915, to Oct. 31, 1920, that I last saw h[illegible] alive on Oct. 31, 1920, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Arteria - sclerosis with cerebral hemorrhage.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis. (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) Wilson Mann, M. D.

Nov. 1, 1920 (Address) City Hospital, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Nov. 2, 1920
20 UNDERTAKER Jno. M. Johnson.	ADDRESS 1234 Eutaw St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0 47750 HEALTH DEPARTMENT—CITY OF BALTIMORE 0 47750

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1144 Hanover ST. 23rd WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Washington Della

(a) RESIDENCE. No. 1144 Hanover ST. 23rd WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of ~~WIFE of~~ Elizabeth Ann Mills

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
76	[illegible]		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Andrew Della

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) U.S.

12 MAIDEN NAME OF MOTHER 1st name unknown. Morse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mary Elizabeth Della (Address) 1144 Hanover St. Balto. Md.

15 Filed NOV 2 - 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 31 1920

17

I HEREBY CERTIFY, That I attended deceased from October 28, 1920, to October 31, 1920, that I last saw him alive on Oct 30, 1920, and that death occurred, on the date stated above, at 8 30 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Ileo Colitis & Uremia

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry F. Buettner M. D.

. 19 (Address) 1049 Riverside Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 2 1920
20 UNDERTAKER	ADDRESS
Fahey & Howe	1318 Riba

MATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47751 HEALTH DEPARTMENT—CITY OF BALTIMORE D47751

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 5225 Melvin ave ST. 37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Charles Ritzius

(a) RESIDENCE. No. 5225 - Melvin ave ST. ..... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Mrs Anna Ritzius

6 DATE OF BIRTH (month, day, and year) June 28 / 1852

7 AGE Years	Months	Days	If LESS than 1 day.. hrs. or .. min.
67	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Food

(c) Name of employer Chas Leight & Son

9 BIRTHPLACE (city or town) (State or country) Europe

PARENTS

10 NAME OF FATHER John J Ritzius

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Anna Byers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe

14 Informant Mr. Herman Rochm
(Address) 5225 Melvin ave

15 Filed NOV 2 - 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/1/20 19

17 I HEREBY CERTIFY, That I attended deceased from Feby ..... 1920, to Nov ..... 1920, that I last saw h.. alive on Oct 31 1920, and that death occurred, on the date stated above, at 345 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? 2919 Norfolk ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam,

(Signed) H. T. Terrey Hough, M. D.

, 19 (Address) 3528 Pk Hghts ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	11-3-1920
20 UNDERTAKER	ADDRESS
Graham & Walker	7330 Park

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D47752 HEALTH DEPARTMENT—CITY OF BALTIMORE D47752

CERTIFICATE OF DEATH.

28

1. PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 1036 N. Stricker St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME Cleveland Louis Barrett

(Residence in Baltimore: No. 1036 N. Stricker St. 15 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH. May 15, 1874 (Month) (Day) (Year)

7-AGE. 46 yrs. 5 mos. 14 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bar Tender 044
(b) General nature of industry, business, or establishment in which employed (or employer): (Saloon)

9-BIRTHPLACE. (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Richard C. Barrett

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Josephine Jones

13-BIRTHPLACE OF MOTHER (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eliz. L. Barrett

(Address) 1036 N. Stricker St.

15. NOV 2 - 1920 ROBERT B KRAUTER

Filed ..... 191.... Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Nov. 1, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. C. D. Hennessy M. D. (Coroner.)

Nov. 2, 1920 (Address) 2802 Edmondson Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodlawn Va	Nov 3rd 1920
20-UNDERTAKER	ADDRESS
J. Putnam Gore	1325 W. Lafayette Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047753 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047753

CERTIFICATE OF DEATH. 4 X 100

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

2-FULL NAME Mrs Elizabeth Coughe

(a) RESIDENCE. No. Ellicott City. Maryland ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 14, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Nicholas Coughe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Hospital Records
(Address)

15 Filed NOV 2 - 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1 1920.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1920. to Nov. 1, 1920.
that I last saw her alive on Nov. 1, 1920,
and that death occurred, on the date stated above, at 11.55 m.

The CAUSE OF DEATH* was as follows:

Ludwig's Angina

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Edema Glottis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Nov. 1, 1920

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Cyrus J Horner M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 4 1920
20 UNDERTAKER Easton Sons	ADDRESS Ellicott City

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Patient was operated for
Cellulitis of neck and three
hours later developed Edema of
Larynx. A tracheotomy was done
but patient was very toxic and
died a few minutes after the
tracheotomy was done. The primary
focus of infection was unknown

Cyrus F. Horine M.D.

Spec.—8-24-14—M. & T.—2000 Bks.

D47784 HEALTH DEPARTMENT—CITY OF BALTIMORE D47784

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 138 Williams St ST. 20 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry George Gaetner

(Residence in Baltimore: No. 138 Williams St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	colored	Single

6-DATE OF BIRTH, November (Month) 3 (Day), 1900 (Year)

7-AGE, 20 yrs. 11 mos. — ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Grocery

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Gaetner

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Kate Michael

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Gaetner

(Address) 138 Williams St

15- Filed NOV 3 - 1920, 191.. ROBERT B KRAUTER Registrar. Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 30 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 14 1920, to Oct 30 1920, that I saw h...alive on Oct 30 1920, and that death occurred, on the date stated above, at 9 30 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

Adenocarcinoma

(Duration) ....yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Endocarditis Pulmonary

Oedema (Duration) 8 yrs. 2 mos. ....ds.

(Signed) Drs Kelly & Kelly M. D.

Nov. 1, 1920 (Address) 215 Holliday

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL,
Loudon Park Cem	Nov 3, 1920
20-UNDERTAKER	ADDRESS
Geo Lemmon & Co	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047755 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047755

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 N. Central Ave ST.: 9 WARD)

REGISTERED NO. 39

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Janet L. Hennas

(a) RESIDENCE NO. 1505 N. Central Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. 6 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 8 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germantown
(State or country) Pa.

PARENTS

10 NAME OF FATHER Chas. J. Hennas

11 BIRTHPLACE OF FATHER (city or town) Connecticut
(State or country)

12 MAIDEN NAME OF MOTHER Bertha Shutter

13 BIRTHPLACE OF MOTHER (city or town) Pa.
(State or country)

14 Informant Mr. Chas. J. Hennas
(Address) 1505 N. Central Ave.

15 Filed NOV 3 - 1920 ROBERT E. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV-3-1920

17 I HEREBY CERTIFY, That I attended deceased from SEP 3 1920, 19..., to NOV-2-1920, 19..., that I last saw h... alive on NOV-2-1920, 19..., and that death occurred, on the date stated above, at 12.45 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart due to Pneumothorax, and old pleurisy infected after Influenza of recent date (duration) X yrs. X mos. 12 ds.

CONTRIBUTORY (Secondary) Acute Influenza and possibly tuberculosis (duration) X yrs. 2 mos. X ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. H. Decker, M. D.

NOV , 19 (Address) 928 E. North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wrightsville - Pa.	Nov. 5 1920
20 UNDERTAKER	ADDRESS
Henry Hoch (Son)	1301 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L47756

L47756

CERTIFICATE OF DEATH.

120

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew aged Home for Incurables St. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca Krauder

(Residence in Baltimore: No. 2001 E. Baltd street St.; 70 yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Widow

6-DATE OF BIRTH, ... Unknown ....., 1 .....
(Month) (Day) (Year)

7-AGE	If LESS than 1 day,
..... 73 — — ..... yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Lewis

(Address) 1411 E Balto st

15- Filed NOV 3 - 1920, 191.... ROBERT F KRAUTER Clerk
Burial Permit Required

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 1st, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1920, to Nov 1 1920, that I saw her alive on Nov 1 1920, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

..... Mitral Regurgitation .....

..... (Duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) M D Barnard M. D.

11/2, 1920 (Address) 210 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. 26 mos. ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence Lombard near Eutaw st

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Mt Carmel	11-3, 1920

20-UNDERTAKER	ADDRESS
Jack Lewis	1411 E Balto st

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47757

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 D 47757

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Med. & Gen. Hosp. ST.: 11 WARD)

2-FULL NAME Baby Irvin

(a) RESIDENCE. No. Md. General Hospital ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 30, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Albert Irvin

11 BIRTHPLACE OF FATHER (city or town) St. Louis
(State or country) Miss.

12 MAIDEN NAME OF MOTHER Alecia Keller

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Maryland

14 Informant Albert Irvin
(Address) 814 Linden Ave.

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk

NOV 9 - 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1920, to Nov. 2, 1920, that I last saw her alive on Nov. 2, 1920, and that death occurred, on the date stated above, at 2:30 a. m.

The CAUSE OF DEATH* was as follows:

Dystocia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Atelectasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? U. G. N.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Manifestations

(Signed) Fred B. Smith, M. D.

, 19 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	Nov. 3 1920
20 UNDERTAKER	ADDRESS
H. Sander Sons	120 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047758 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047758

CERTIFICATE OF DEATH. 43

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 800 E. 22nd ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa E. Baker

(a) RESIDENCE. No. 800 E. 22nd. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Baker

6 DATE OF BIRTH (month, day, and year) Dec. 24-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A. Hambleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Gina Ross

(Address) 800 E. 22nd St.

15 NOV 3 - 1920 ROBERT J. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1919, to Nov. 2, 1920, that I last saw her alive on Nov. 1, 1920, and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Carcinoma of right Breast
(Recurrent about 3 yrs after ops.)
Involving chest, right arm etc.

(duration) 6 yrs. mos. ds.

CONTRIBUTORY ~~(Secondary)~~

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Mar. 1915

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings

(Signed) Harrison F. Cooper M. D

11-2 1920 (Address) 2425 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Michaels Md	Nov 4th 1920
20 UNDERTAKER	ADDRESS 1639
E. Schloman & Son	Hanover St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Rks.

D47759

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47759

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 522 N. Carrollton Ave (STREET) 18 (WARD)

REGISTERED No. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A Griffin

(a) RESIDENCE. No. 522 N. Carrollton Ave WARD. 18

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah R. Griffin

6 DATE OF BIRTH (month, day, and year) Jan 29 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter & Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER James C. Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Elizabeth Bracken

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs R. Griffin (Address) 522 N Carrollton Ave

15 Filed NOV 3 - 1920 ROBERT F KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1919 to Oct 31 1920

that I last saw h alive on Oct 31 1920

and that death occurred, on the date stated above, at 10-50 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. Lankford M. D.

(Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov 3 1920

20 UNDERTAKER Chas. G. Black ADDRESS 742 W North Ave

Manscript

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D47760 HEALTH DEPARTMENT--CITY OF BALTIMORE D47760

92-12

CERTIFICATE OF DEATH

REGISTERED No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1617 Laurens ST.: 16 WARD)

2-FULL NAME Alexander Lenz, Jr.

(Residence in Baltimore: No. 1617 Laurens St.: 4 yrs. 4 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: June (Month) 6 (Day) 1851 (Year)

7-AGE: 69 yrs. 4 mos. 25 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Baker but has not worked for several years
(b) General nature of industry, business, or establishment which employed (or employer)

9-BIRTHPLACE (State or country): Baltimore, Md.

PARENTS

10-NAME OF FATHER: Alexander Lenz

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Louisa Black

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Agnes I Lenz

(Address) 1619 Laurens St

15- NOV 3 - 1920 Filed .... 191 ....

ROBERT B KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Oct (Month) 31 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25, 1920, to, Oct 31 1920 that I saw him alive on Oct 31, 1920 and that death occurred, on the date stated above, at 3:15 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) .... yrs. .... mos. 24 hrs

Contributory (SECONDARY) Cirrhosis of Liver

(Duration) .... yrs. .... mos. .... ds.

(Signed) Wm. M. Lewis M. D.

Oct 31, 1920 (Address) Lutherville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore

DATE OF BURIAL: Nov 3, 1920

20-UNDERTAKER: Daniel Easton

ADDRESS 916 Pennsylvania

Spec.—8-24-14—M. & T.—2000 Blks.

2447761 HEALTH DEPARTMENT—CITY OF BALTIMORE 2447761

CERTIFICATE OF DEATH.

119

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Pierce ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mattie Robinson

(Residence in Baltimore: No. 706 Pierce St.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word.) Married

6-DATE OF BIRTH, ..., 1885
(Month) (Day) (Year)

7-AGE, 35 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Georgia

PARENTS.

10-NAME OF FATHER Phil Robinson

11-BIRTHPLACE OF FATHER (State or Country), Georgia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Pa ave

15-

Filed NOV 3 1920, 191..... ROBERT J. KLAETER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 31, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 20 1920, to Oct 31 1920, that I saw her alive on Oct 31 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Nephritis

(Duration) Hr's history yrs. mos. ds.

CONTRIBUTORY (Secondary).....

(Duration) yrs. mos. ds.

(Signed) John B Stewart M. D.

1111, 191.. (Address) 1540 W Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Nov 3, 1920

20-UNDERTAKER David Easton

ADDRESS 916 Pa ave

USE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047762 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047762

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 E. Monument St.; 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Smith

(a) RESIDENCE. No. 1623 E Monument St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70 yeo			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) M D

PARENTS

10 NAME OF FATHER John Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Jeanette Johns
(Address) 1623 E Monument St

15 Filed NOV 3 — 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 28, 1920, to Nov 1, 1920, that I last saw h[er] alive on Oct 31, 1920, and that death occurred, on the date stated above, at 7, 15 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J. Edward Fisher M. D.

Nov 2 1920 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon National Cemetery	Nov 5 1920
20 UNDERTAKER Mrs Robt A Elliott	ADDRESS 1725 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D47763 HEALTH DEPARTMENT—CITY OF BALTIMORE D47763

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH
CITY OF BALTIMORE (No. #901-W. Hoff St. 13 WARD)
REGISTERED No. C.....

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emmalie Wells

(Residence in Baltimore: #901-W. Hoffman St.; yrs., 0 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Mar 19, 1836
(Month) (Day) (Year)

7-AGE. 84 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) At Home

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER Thomas Wells.

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Anna Mabrose

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Cruxburn

(Address) Balto Md

15- Filed NOV 3 - 1920 ROBERT B. KRAUTER Burial Permit Officer Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Nov 1st, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Harry Harrison M. D.
Coroner.

Nov 1st, 1920 (Address) 732 Rolandson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem — DATE OF BURIAL, Nov 3. 1920

20-UNDERTAKER Chenoweth & Son — ADDRESS Chestnut Ave

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47764

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47764

CERTIFICATE OF DEATH.

+ 45

1-PLACE OF DEATH U.S Public Health Service Hospital #56 REGISTERED NO.

CITY OF BALTIMORE: (No. Fort McHenry Baltimore Md. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Poindexter

(a) RESIDENCE. NO. U.S Public Health Services Hospital #56 Ft McHenry Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28 yrs	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): ----

(c) Name of employer: ----

066

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Edgar T. Rosenbush (Address) Ft McHenry Baltimore Md

15 Filed NOV 3 - 1920 19 ROBERT E KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 19 20

17

I HEREBY CERTIFY, That I attended deceased from Sept, 17 , 19 20 to Nov, 2 , 19 20.

that I last saw h im live on Nov 2 , 19 20.

and that death occurred, on the date stated above, at 355 p.m

The CAUSE OF DEATH* was as follows:

Sarcoma femur left upper 3rd.

--------- (duration) ---------- ds.

CONTRIBUTORY (Secondary) ---------

---------(duration)---------- mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of ---

Was there an autopsy? no

What test confirmed diagnosis? Pathologic Exam.

(Signed) Thomas R Bevagne, M. D

. 19 (Address) Fort McHenry Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lynchburg Va

DATE OF BURIAL: Nov. 3 1920

20 UNDERTAKER: D Spurrier & Bro

ADDRESS 1121 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47765

CERTIFICATE OF DEATH.

28 D 47765

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 N Durham ST.; 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Jackson Fennick

(Residence in Baltimore: No. 1011 N Durham St.; ... yrs., ... mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Black	Single

6-DATE OF BIRTH, Aug (Month) 13 (Day), 1886 (Year)

7-AGE, 34 yrs. 2 mos. 19 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): General Laborer

9-BIRTHPLACE (State or Country): Ft Marys C. Md

PARENTS.

10-NAME OF FATHER: Joseph Fennick

11-BIRTHPLACE OF FATHER (State or Country): Ft Marys C. Md

12-MAIDEN NAME OF MOTHER: Martha Robinson

13-BIRTHPLACE OF MOTHER (State or Country): Ft Marys C. Md

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Fennick

(Address) 1011 N. Durham

15-

Filed OCT 3 1920 191 ROBERT B. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 2 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 12 1920, to Nov 2 1920, that I saw him alive on Nov 1 1920, and that death occurred, on the date stated above, at 11a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) — yrs. 10 mos. — ds.

CONTRIBUTORY (Secondary) Pleurisy

(Duration) ... yrs. 7 mos. — ds.

(Signed) W. S. Coppage M. D.

Oct 2, 1920 (Address) 2303 N. Calvert

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel	Oct. 4 191
20-UNDERTAKER William Cook	ADDRESS 502 E. Hatt Av.

Be sure that DATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47766

CERTIFICATE OF DEATH.

28 D47766

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 Columbia Ave. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Tamburo

(a) RESIDENCE. No. 817 Columbia Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced (or) WIFE of alice Tamburo

6 DATE OF BIRTH (month, day, and year) March 21, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
22	yrs.	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Independent people

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Salvatore Tamburo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Concetta Pitto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Concetta Pitto
(Address) 817 Columbia ave

15 Filed ....., 19 .....

NOV 3 - 1920

ROBERT P. LAMDIN
Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1920

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1920, to Nov 1, 1920, that I last saw h... alive on Nov 1/20, 19..., and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Gram T. Bacilli found

(Signed) Wm L Cavaleck, M. D.

, 19 (Address) 1058 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 4- 1920
20 UNDERTAKER	ADDRESS
William Cook	502 S. North Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047767

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047767

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1829 W. Lombard St. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Lewis Owings

(a) RESIDENCE. No. 1829 W. Lombard St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura J. Owings

6 DATE OF BIRTH (month, day, and year) May 3, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Carnagie Steel Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore County
(State or country) Maryland

PARENTS

10 NAME OF FATHER Israel E. Owings

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Panela Dyer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Laura J. Owings
(Address) 1829 W. Lombard St.

15 NOV 8 - 1920 ROBERT P. LAMB Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1 19 20

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1919, to Nov 1, 1920, that I last saw him alive on Nov 1, 1920, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic nephritis Latent Interstitial

(duration) yrs.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) Walter A Cox, M. D.

11. 2. 1920 (Address) 343 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL Nov 4 1920

20 UNDERTAKER Jos Block — ADDRESS 1003 W Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047768

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 047768

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Mantz

(a) RESIDENCE. NO. 117 S. Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E Mantz

6 DATE OF BIRTH (month, day, and year) June 20, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	4	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Railroad Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) 073
(c) Name of employer Bal. & O. R. R.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Peter Mantz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md.

12 MAIDEN NAME OF MOTHER Elizabeth Corbin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Benj. F. Mantz
(Address) 117 So. Gilmor St.

15 Filed ....., 19 ..... Registrar

NOV 3 – 1920

ROBERT B KRAUTER
Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 2 1920

17 I HEREBY CERTIFY, That I attended deceased from October 29 1920, to November 2, 1920, that I last saw him alive on November 2, 1920, and that death occurred, on the date stated above, at 800 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis.

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings & Laboratory

(Signed) C. Wilbur Stewart, M. D.

11/2, 1920 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Nov 6th 1920
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Pks.

D47769 HEALTH DEPARTMENT—CITY OF BALTIMORE D47769

164

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Meil. Stark. ST.; | WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence. Whitemore Jr.

(a) RESIDENCE. No. Hillsdale Md. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 18" 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Clarence Whitmore

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Etta Townsend.

13 BIRTHPLACE OF MOTHER (city or town) Balto Co
(State or country) Md.

14 Informant Clarence Whitmore.
(Address) Hillsdale Md.

15 Filed ....., 19.....
NOV 3 – 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1920 to Nov. 2, 1920, that I last saw him alive on Nov. 2, 1920, and that death occurred, on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pleurisy

(duration) yrs. mos. 7. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Md. Meil. Stark.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical manifestations

(Signed) Fred B. Smith, M. D.

, 19 (Address) Md. Meil. Stark.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Nov. 3" 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

047770

HEALTH DEPARTMENT—CITY OF BALTIMORE

047770

CERTIFICATE OF DEATH.

79-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital, WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Mifsud

(Residence in Baltimore: No. Maple Ave near Forest Ave St.; 61 yrs. 3 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. July 7, 1855 (Month) (Day) (Year)

7-AGE. 61 yrs. 3 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country) Baltimore City

PARENTS.

10-NAME OF FATHER. John Mifsud

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Katherine Kelly

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos F. Mifsud Bro

(Address) Woodlawn P.O.

15- NOV 3 - 1920 ROBERT J. KRAUTER

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. November 1st, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 30th 1920, to Nov 1st 1920, that I saw h Se alive on Nov 1st 1920, and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Valvular Heart

Trouble (Duration) ... yrs. ... mos. 3 ds.

(Signed) Geo J. Courbat M. D.

Nov 1st, 1920 (Address) Woodlawn Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Was at Hospital only 4 hours.

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. New Cathedral | DATE OF BURIAL. Nov. 4th, 1920

20-UNDERTAKER Joseph B. Cook | ADDRESS 1103 N Bond St

See instructions on back of certificate.

Spec. 6-8-19—H. P. Co.—1000 Bks.

Burley.

~~647771~~ HEALTH DEPARTMENT—CITY OF BALTIMORE ~~647771~~

91-089

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 N. Gilmor St ST.: 19 WARD)

2-FULL NAME Agnes Burley

(a) RESIDENCE. NO. 408 N. Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 1/2 ds. How long in U. S., if of foreign birth? yrs. 20

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20-20

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Jail

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Richard Burley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Richard Butler
(Address) 408 N Gilmor

15 Filed NOV 3 1920 ROBERT J. CLATTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 31 1920 to Nov. 1 1920 that I last saw her alive on October 31 1920 and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchitis + Colds

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Lloyd Kennard M. D.
11-1- 1920 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W Fairview	Nov 3 1920
20 UNDERTAKER	ADDRESS
Sam'l N. Glass & Son	1400 Madison

IT IS IMPORTANT that this CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

047772 HEALTH DEPARTMENT—CITY OF BALTIMORE 047772

92

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 Woodyear ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Johnson

(Residence in Baltimore: No. 710 Woodyear St.; 38 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, ... June (Month) ..... Unknown (Day), 1882 (Year)

7-AGE, 38 yrs. 10 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... (Blind)

9-BIRTHPLACE, (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, Alfred Johnson

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alfred Johnson

(Address) 710 Woodyear

15-

Filed NOV 3 - 1920, 191.... ROBERT R. KRAUTER, Registrar.

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 1 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 22 1920, to Nov 1 1920, that I saw him alive on Oct 31 1920, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

..... (Duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) Do Anemia

..... (Duration) ..... yrs. ..... mos. 9 ds.

(Signed) C. H. Horne M. D.

Nov, 1920. (Address) 714 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Nov 3 1920

20-UNDERTAKER Samuel Hendy ADDRESS 5 & Bell

Please classified. Exact statement of OCCUPATION is very important, as that it may be properly coded. See instructions on back of certificate.

Carpenter

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047773 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047773

CERTIFICATE OF DEATH. 64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Carpenter

(a) RESIDENCE. No. 804 Sarah ann ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of annie Carpenter

6 DATE OF BIRTH (month, day, and year) July 12 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Edgewood

(c) Name of employer Pow. Works

9 BIRTHPLACE (city or town) (State or country) Australia

PARENTS

10 NAME OF FATHER A. Carpenter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire.

12 MAIDEN NAME OF MOTHER Ellen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash. D. C.

14 Informant Annie Carpenter (Address) 804 Sarah ann

15 NOV 3 - 1920 ROBERT B. BAUER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/31 1920

17 I HEREBY CERTIFY, That I attended deceased from 10/25 1920, to 10/31 1920, that I last saw h[illegible] alive on 10/31 1920, and that death occurred, on the date stated above, at 10.55 p. m.

The CAUSE OF DEATH* was as follows:

Hypertension - Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene A. Rudisill, M. D.

11/1. 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Nov 4 1920
20 UNDERTAKER	ADDRESS
Samuel F. Hensley	1711 Bolton

SEE INSTRUCTIONS ON BACK OF CERTIFICATE. PHYSICIANS should state plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47774

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47774

CERTIFICATE OF DEATH.

REGISTERED NO. 77

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2636 Dulaney St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Jane Sieck

(a) RESIDENCE. No. 2636 Dulaney St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 1 mos. X-5 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Henry Sieck 1858

6 DATE OF BIRTH (month, day, and year): Sept 28=1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (City or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Adam Deems

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md

Informant: Florence L. Bobbit

(Address) 536 Brunswick St

15 Filed NOV 3 — 1920 Registrar

ROBERT S. BRUCE

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 2 19 20

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st, 19 20, to Nov 2, 19 20, that I last saw h... alive on Nov 2, 19 20, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Indefinite (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Dilitation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jeffery Glassman, M. D.

, 19 (Address) 202 E. Preston Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Nov 4 19 20

20 UNDERTAKER: T. B. Heppard ADDRESS 2236 Fred'k Ave

it may be properly classified. Exact statement of OCCUPA-
tain terms, so that it ma
on back of certificates.
tant. See instructions on

D47775 HEALTH DEPARTMENT—CITY OF BALTIMORE D47775

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 120-W 21 St.; 12 Ward) REGISTERED No. C.....

2-FULL NAME Harold E. Simms (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 120-W 21 St. St.; yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
M.	C.	Married

6-DATE OF BIRTH, Oct 31, 1919
(Month) (Day) (Year)

7-AGE, 35 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) St Mary's Co Md

PARENTS.

10-NAME OF FATHER Albert E. Simms

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Jane Jenifer

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Jenifer

(Address) 1802 N. Edmondson

15- Filed NOV 3 - 1920, 191.....

ROBERT P. BRADLEY
Burial Permit Officer
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 31, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Harrison M. D.
(Coroner.)

Nov 3 1920 (Address) 3612 Roland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	Nov. 3, 1920
20-UNDERTAKER	ADDRESS
Mrs. E. Locke	1302 Jeffer

Filed in duplicate. AGE should be stated EXACTLY. PHYSICIANS should state carefully supplied. ...ms, so that it may be properly classified. Exact statement of OCCUPATION is very ...r be ... on back of certificate.

AGE should be stated EXACTLY. PHYSICIANS should ... properly classified. Exact statement of OCCUPATION is very ... that it may be prope... back of certificate.

0947776 HEALTH DEPARTMENT—CITY OF BALTIMORE 0947776

CERTIFICATE OF DEATH.

175-004

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fleming Miller.

(Residence in Baltimore: No. 4303 Belview Ave. St.: 1 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH, Do not know. (Month) (Day) 1 (Year)

7-AGE, 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman.
(b) General nature of industry, business, or establishment in which employed (or employer): 066

9-BIRTHPLACE, (State or Country): Alabama.

PARENTS.

10-NAME OF FATHER: W.S.Miller.

11-BIRTHPLACE OF FATHER (State or Country): Do not know.

12-MAIDEN NAME OF MOTHER: Do not know.

13-BIRTHPLACE OF MOTHER (State or Country): Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. H.S. Hartage.

(Address) 4303 Belview Ave.

15- NOV 3 - 1920 ROBERT S KRAUTER
Filed ..., 191... REGISTRAR.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 31st, 1920. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidentally struck by car
#349 of U.Ry & E.Co.
10/29/20. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) H. K. Reinhardt (Coroner)

Nov 3rd, 1920. (Address) 1017 S. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Belview & Leona Ave.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Fairmount Mem. | DATE OF BURIAL, ..., 19...

20-UNDERTAKER E.LeRoy Stephen | ADDRESS 1245 Nath. Av.

Spec.—8-24-14—M. & T.—2000 Blks.

1047777

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047777

152

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Robinson

(Residence in Baltimore: No. 4212 Springdale Ave. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	—

6-DATE OF BIRTH, November (Month) 2 (Day), 1920 (Year)

7-AGE, 0 yrs. 0 mos. 1 ds. If LESS than 1 day, 10 hrs. or 0 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work — —
(b) General nature of industry, business, or establishment in which employed (or employer) — —

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Morris Robinson

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Celia Harris

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [redacted] Lewis

(Address) 1411 E. Baltimore

15- NOV 3 - 1920 Filed ....., 191... ROBERT S. STAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 2 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 2, 1920, to Nov 2, 1920, that I saw him alive on November 2, 1920, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Atelectasis Pulmonum

(Duration) 0 yrs. 0 mos. 1 ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Greenberg M. D.

Nov. 3, 1920. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Cemetery	Nov 3, 1920
20-UNDERTAKER Jack Lewis	ADDRESS 1411 E. Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

LQ47778 HEALTH DEPARTMENT—CITY OF BALTIMORE LQ.47778

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S Public Health Service Hospital #56 REGISTERED NO.

CITY OF BALTIMORE: (No. Fort McHenry Balt more Md. ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James B, Adams

(a) RESIDENCE. NO. 667 Columbia Ave Baltimore ST. Md. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs A Adams, wife

6 DATE OF BIRTH (month, day, and year) Aug 2. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53 yrs	----------	--	-- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Deck Watchman Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Old Boy Line

(c) Name of employer -----

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Edgar T. Rosenbush Registrar

(Address) Fort McHenry Baltimore Md.

15 Filed Robert P. Harrison, Registrar

NOV 3 - 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2nd. 1920

17 I HEREBY CERTIFY, That I attended deceased from October 7 19 20 to Nov, 2 19 20

that I last saw him alive on Nov, 2 19 20

and that death occurred, on the date stated above, at 8,10 pm.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis, parenchymatous

---------- (duration) --- yrs. -- mos. -- ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -----

Did an operation precede death? --- Date of ---

Was there an autopsy? ------- no

What test confirmed diagnosis? laboratory findings

(Signed) Thomas B. Payne, M. D.

, 19 (Address) Fort McHenry Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Portobello St Works Co Md	Nov 6" 1920
20 UNDERTAKER	ADDRESS 1422
Margaret E. Flynn	Light St.

GENERAL.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D47779

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47779

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 Cypress ST. 25 WARD) REGISTERED NO. C 28

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H. Griffin Sr.

(Residence in Baltimore: No. 124 Cypress St St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widower

6-DATE OF BIRTH, July 7, 1870
(Month) (Day) (Year)

7-AGE, 50 yrs. 3 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baker-master
(b) General nature of industry, business, or establishment in which employed (or employer): Barber Shop

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Paul Griffin

11-BIRTHPLACE OF FATHER (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Bridget Flully

13-BIRTHPLACE OF MOTHER (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George H. Griffin Sr

(Address) 124 Cypress St

15- NOV 3 — 1920 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 1, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1920, to Nov 1 1920, that I saw him alive on Oct 30 1920, and that death occurred, on the date stated above, at 10h m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) months

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Harlan M. D.

Nov 2, 1920 (Address) 1 Cedar St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: New Cathedral — DATE OF BURIAL, Nov. 5, 1920

20-UNDERTAKER: Margaret J. Flynn — ADDRESS 1422 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-20—H. P. Co.—1000 Bks.

20,47780 HEALTH DEPARTMENT—CITY OF BALTIMORE 20,47780

CERTIFICATE OF DEATH. X 104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Morsell

(a) RESIDENCE. No. 1631 Eastern Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 20 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Wm Morsell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record
(Address) J. H. H.

15 Filed NOV 8 - 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29th 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 28th, 1920, to Oct 29th, 1920, that I last saw him alive on Oct 29th, 1920, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Diarrhoea 1st Dysentery

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W Harrison M. D.

, 19 (Address) J H H Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	NOV 1 - 1920
20 UNDERTAKER	ADDRESS

Commissioner of Health.

17615

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47781

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47781

CERTIFICATE OF DEATH.

151

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hosp. ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hardy

(a) RESIDENCE. NO. Glenbernie Md ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 Day, ... hrs. or 40 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Leonard Hardy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Stewart.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant ... (Address) ...

15 Filed NOV 3 - 1920 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 1 1920

17

I HEREBY CERTIFY, That I attended deceased from 10-31, 1920, to 11 - 1, 1920,

that I last saw h... alive on 11 - 1, 1920,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Abortion (accidental)(ie
menstruation + therapeutic)
1½ lb foetus.

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) Zoe Stookey, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	NOV 3 - 1920 19
20 UNDERTAKER	ADDRESS

Burial Permit Clerk.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Examine statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47782 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47782

CERTIFICATE OF DEATH.

41

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital WARD)

2-FULL NAME Mrs. Rose Newman

(a) RESIDENCE. No. 2321 Callow Ave WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? V yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr Edw. Newman

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 65 Months 4 Days 0 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Not any

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Donat Fredu

11 BIRTHPLACE OF FATHER (city or town) (State or country): " "

12 MAIDEN NAME OF MOTHER: Mina Lulfes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Mr E. Newman

(Address) 2321 Callow Ave

15 Filed ..... 19 Robert P. Harrison, Registrar

NOV 3 — 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 3 19 20

17 I HEREBY CERTIFY, That I attended deceased from 10-12, 19 20, to 11-12, 19 20, that I last saw h[illegible] alive on 11-3, 19 20 and that death occurred, on the date stated above, at 3.00 P.M.

The CAUSE OF DEATH* was as follows:

Carcinnoma of the Rectum

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) W. M. Craig M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship — DATE OF BURIAL: 11/5" 1920

20 UNDERTAKER: David Sondheim — ADDRESS: 18 Mt. Royal Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.47783

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47783 HEALTH DEPARTMENT—CITY OF BALTIMORE

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2141 Huntingdon Ave ST.: 17 WARD)

2-FULL NAME Anna Eliza Moore

(a) RESIDENCE. No. 2141 Huntingdon Ave ST., 12 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edmond Burke Moore

6 DATE OF BIRTH (month, day, and year) Nov. 5-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home-wife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Perry Co. Pa.

PARENTS

10 NAME OF FATHER Daniel Hallman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary Krill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Edmond B. Moore Jr.

(Address) 2141 Huntingdon Ave

Filed NOV 1920. Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov-1, 1920, to Nov-2, 1920, that I last saw her alive on Nov 1, 1920, and that death occurred, on the date stated above, at 6.15 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Coma)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac-insufficiency

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Roscoe G. Cross, M. D.

, 19 (Address) 2438 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Nov. 5 1920
20 UNDERTAKER Horace Bridges & Son	ADDRESS 363 Fulton Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D.47784

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47784

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3813 Falls Road ST.; 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgeanna Crowther

(Residence in Baltimore: No. 3813 Falls Road St. 59 yrs., mos., ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Oct. 9-, 1846
(Month) (Day) (Year)

7-AGE, 74 yrs. — mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): General Housework

9-BIRTHPLACE, (State or Country), Baltimore County

PARENTS.

10-NAME OF FATHER, Thomas L. Kelley

11-BIRTHPLACE OF FATHER (State or Country), Balto County

12-MAIDEN NAME OF MOTHER Rebecca Birnick

13-BIRTHPLACE OF MOTHER (State or Country), Balto County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie C. Rose

(Address) 3813 Falls Road

15- NOV. 3 - 1920, 191.... Robert P. Harrison,
Filed Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 3d, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1st 1912 8, to nov. 3rd 1920, that I saw h r alive on nov 3rd 1920, and that death occurred, on the date stated above, at 4 30 A m.

The CAUSE OF DEATH* was as follows: Paralysis due to Cerebral Hemorrhage

(Duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) arteri-sclerosis

(Duration) 1 yrs. 6 mos. ds.

(Signed) S. R. Wantz M. D.

Nov 3, 1920 (Address) 865 W. 36th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Marys Hampden — DATE OF BURIAL, Nov. 4 1920

20-UNDERTAKER Horace Burgee Sons — ADDRESS 631 Falls Rd

Spec.—8-24-14—M. & T.—2000 Bks.

D.47785

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47785

CERTIFICATE OF DEATH.

150

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 3907 Roland Ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph & Michael Scheve

(Residence in Baltimore: No. 3907 Roland Ave St.; yrs., 2 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August (Month) 16, (Day) 1920 (Year)

7-AGE, yrs. 2 mos. 17 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Joseph A. Scheve

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Loretta Horrigan

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph A. Scheve

(Address) 3907 Roland Ave

15-

Filed NOV 3 - 1920, 191

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October (Month) 2 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 1920, to Nov 2 1920, that I saw him alive on Nov 2 1920, and that death occurred, on the date stated above, at 8:50 a.m.

The CAUSE OF DEATH* was as follows:

(a) Marasmus

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Enteritis - Bifidus

(Duration) yrs. 2 mos. 16 ds.

(Signed) D. L. Shelley M. D.

Nov 2, 1920 (Address) 3849 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Cathedral

DATE OF BURIAL, Nov 4, 1920

20-UNDERTAKER Horace Burgess

ADDRESS 363 Hall Pl

CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIAN should state important. See instructions on back of certificate. Should be carefully supplied. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

D.47786 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47786

CERTIFICATE OF DEATH.

79

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 Spring Hill Terrace St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Bishop

(Residence in Baltimore: No. 606 Spring Hill Terrace St.; 75 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May 12, 1826.
(Month) (Day) (Year)

7-AGE, 94 yrs. 5 mos. 20 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Wm. J. Bishop

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER ~~Elizabeth Anthony~~ Mary Eliza Anthony

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard G. Bishop

(Address) 2936 N. Calvert St

15-

Filed ..... 191.....

Robert P. Harrison,
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 2, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 12 1920, to Oct 1 1920, that I saw h[illegible] alive on Oct 1 1920, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) W. B. Fox M. D.

Nov 3, 1920 (Address) 836 W. Mt. Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bals Cemetery — DATE OF BURIAL, Nov. 4, 1920.

20-UNDERTAKER E. A. Weidefeld Jr. — ADDRESS 501 E 22nd St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47787 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47787

CERTIFICATE OF DEATH. 50

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 E Oliver ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albin Seidel

(a) RESIDENCE. No. 1715 E Oliver ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 13 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sutton Laundry

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frank Seidel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johana Dogue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs M Coffey
(Address) 1715 E Oliver

15 Filed NOV 3 - 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1920, to Nov 1, 1920 that I last saw h alive on Nov 1, 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Urinalysis

(Signed) John A Arey, M. D.

, 19 (Address) 1603 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	11/5 1920
20 UNDERTAKER: L. A. Moran	ADDRESS 3000 E Balto

NOTICE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.47788

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47788

CERTIFICATE OF DEATH.

64

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 126 n Kenwood St.; 6 WARD)

2-FULL NAME Mary A Gilchrist

(Residence in Baltimore: No. 126 n Kenwood St.; 74 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white.	Widow

6-DATE OF BIRTH. Dec. 11, 1849
(Month) (Day) (Year)

7-AGE, 70 yrs. 10 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Ind.

PARENTS.

10-NAME OF FATHER. Daniel Lynch

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Mary McCaffery

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Busse

(Address) 503 E. Pratt St.

15- Robert P. Harrison,
Burial Permit Clerk Registrar.

NOV 3 - 1920

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Nov 1, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy,

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Emmert Bailey M. D.
(Coroner.)
11-4-20 (Address) 4 E. Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Patricks Cem	Nov 4, 1920
20-UNDERTAKER L. J. Moran	ADDRESS 3000 E. Balto St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D47789 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47789

43

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 W. Mulberry St.; 19 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary S. Courtney

(Residence in Baltimore: No. 1427 W. Mulberry St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
female	white	married

6-DATE OF BIRTH, May (Month) 6 (Day), 1877 (Year)

7-AGE, 43 yrs. 5 mos. 27 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: home wife
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. James Kirby

11-BIRTHPLACE OF FATHER (State or Country). Balto, Md.

12-MAIDEN NAME OF MOTHER Emma Meredith.

13-BIRTHPLACE OF MOTHER (State or Country). Balto, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Courtney (husband)

(Address) 1427 W. Mulberry St

15- NOV 3 - 1920, 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 2 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 15 1916, to November 2 1920, that I saw her alive on October 31 1920, and that death occurred, on the date stated above, at 3:15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(Duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) none

(Duration) — yrs. — mos. — ds.

(Signed) Chester Riland, M. D.

11-2-, 1920 (Address) 2532 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, Nov. 4, 1920

20-UNDERTAKER George J. Smith

ADDRESS Fayette st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47790 D.47790

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

80

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. H m. Priddy

(a) RESIDENCE. No. 1613 Fred. k Ave WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Virgie D

6 DATE OF BIRTH (month, day, and year) July 24, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Electrician

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mrs. Virgie D.
(Address) 1613 Fred k Ave

15 Filed NOV 3 - 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3 1920

17 I HEREBY CERTIFY, That I attended deceased from 10-7, 1920, to 11-3, 1920, that I last saw him alive on 11-3, 1920, and that death occurred, on the date stated above, at 6.00 9 p.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Endocarditis, Acute Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) W. M. Craig, M. D.

. 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Nov 5 1920
20 UNDERTAKER	ADDRESS
Geo J Smith	1000 E Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.47791

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47791

120

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2202 E Monument St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Hoffman

(Residence in Baltimore: No. 2202 E Monument St.; Life yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec 25 (Month) (Day), 1854 (Year)

7-AGE, 66 yrs. 10 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): 07

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Louis Kreh

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Eva Ka Walk

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis W Hoffman

(Address) 2202 E Monument

15-

Filed NOV 3 - 1920, 191.....

Robert P. Harrison,
Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 2 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 2 1920, to Nov. 2 1920, that I saw her alive on Nov. 2 1920, and that death occurred, on the date stated above, at 7.40 p. m.

The CAUSE OF DEATH* was as follows:

Interstitial Pneumonitis - Uraemia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(Duration) yrs. mos. ds.

(Signed) Wm F McNutt M. D.

Nov 3 - 1920 (Address) 701 N Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL, Nov 5th 1920

20-UNDERTAKER Wm J. Hartley

ADDRESS 815 N Washington St

Spec.—8-24-14—M. & T.—2000 Blks.

D.47792 ✓ D.47792

HEALTH DEPARTMENT—CITY OF BALTIMORE

92

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2206 Eager Place ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew L. Hierstetter

(Residence in Baltimore: No. 2206 Eager Place St.; Life yrs. mos. ds.)

CAUSE OF DEATH should be stated EXACTLY. PHYSICIAN'S ... state important. See instructions on back of certificate. AGE ... properly classified. Exact statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, June 18th, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 4 mos. 16 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Andrew Hierstetter

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Hilda Burns

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Hierstetter

(Address) 2206 Eager Place

15- Filed NOV 3 1920, 191.... Robert P. Harrison, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 2nd (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-24-20 191..., to 11-2-20 191..., that I saw him alive on 11-2-20 191..., and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

11-2-20, 191... (Address) 225 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cem	Nov. 4th, 1920
20-UNDERTAKER	ADDRESS
Jas. L. Miller	233 Jefferson

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Tryman)

D. 47793 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 47793

CERTIFICATE OF DEATH.

1441/32

115-091

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp. ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Tryman

(a) RESIDENCE. No. 516 Lewis St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH must be stated EXACTLY. PHYSICIAN should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April-1890

7 AGE: 30 Years | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) W. Virginia

PARENTS

10 NAME OF FATHER Sam Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Strawbridge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Husband (Regd) (Address) J. H. K

15 Filed NOV 3 - 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2nd 1920.

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1920, to Nov 2nd, 1920, that I last saw him alive on Nov 2nd, 1920, and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute cholecystitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Roger G. Dougherty, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bolivar. W. Va — DATE OF BURIAL: Nov 4 1920

20 UNDERTAKER: John H. Toadvine — ADDRESS 142 Watts St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47794

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47794

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. / WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Montemont

(a) RESIDENCE. No. 931 Madison Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

021

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M. T. H.

15 Filed NOV 3 1920 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1, 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct. 30th, 1920, to Nov. 1, 1920, that I last saw him alive on Nov. 1, 1920, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. J. Rigney, M. D.

Nov. 1, 1920 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Milford - Ra	11-4 1920
20 UNDERTAKER Lonson & Jones.	ADDRESS 12 N. Greene St.

CAUSE OF DEATH must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates. May be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 47795 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 47795

CERTIFICATE OF DEATH. X 45

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., WARD)

2-FULL NAME Mr. John Mc Donald

(a) RESIDENCE. NO. Aberdeen N. C. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 1 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Oct 14-1887

7 AGE: Years 32 yrs. Months — Days 20. If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Gen'l
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: A. B. Mc Donald

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know

12 MAIDEN NAME OF MOTHER: Eddie Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know

14 Informant: Miss Nannie Mc Donald (Address) Aberdeen, N. C.

15 Filed NOV 5 - 1920, 19.... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-3 1920

17 I HEREBY CERTIFY, That I attended deceased from 9-20, 1920, to 11-3, 1920, that I last saw him alive on 11-3, 1920, and that death occurred, on the date stated above, at 6:15 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma recurrent glands of neck.

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema & cardiac failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? France

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. McCraig, M. D.

11-3, 1920 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Aberdeen N. C.

DATE OF BURIAL: Nov 4th 1920

20 UNDERTAKER: H B Kippert

ADDRESS 226 Fayetteville St

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47796 ✓ D.47796

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 S. High Street ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Voglein

(a) RESIDENCE. NO. 11 S. High Street ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of * * *

6 DATE OF BIRTH (month, day, and year) May 4—1920

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) * * *

(c) Name of employer * * *

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER James J. Voglein

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Nov 3 Mannie Langan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mannie Voglein
(Address) 11 S. High Street.

15 Filed NOV 3—1920 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3rd 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 25 , 19 20 , to Nov 3 , 19 20 ,

that I last saw h... alive on Nov 3 , 19 20 ,

and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Auto Gastric Enteritis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. J. Valentine, M. D.

Nov 3 , 19 20 (Address) 811 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincent Cemetery.	11/4/20 19
20 UNDERTAKER	ADDRESS
Chas. P. Evans & Son	114 E. Mon.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47797 D 47797

CERTIFICATE OF DEATH.

104

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1821 Hanover ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Butcher

(Residence in Baltimore: No. 1821 Hanover St.; ....yrs.,....mos.....da.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) M/W

6-DATE OF BIRTH, ... July (Month) 27 (Day), 1920 (Year)

7-AGE, ...yrs. 3 mos. 6 da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Balto

PARENTS.

10-NAME OF FATHER, William Butcher

11-BIRTHPLACE OF FATHER (State or Country). Balto

12-MAIDEN NAME OF MOTHER Mary Mathews

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William J. Butcher

(Address) 1821 Hanover

15- NOV 4 - 1920 191.... G. H. Grese. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov (Month) 2 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 31 1920, to Nov 2 1920, that I saw h[illegible] alive on Nov 2 1920, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

..... (Duration) ....yrs. ....mos. 5 da.

CONTRIBUTORY (Secondary) William Watson

..... (Duration) ....yrs. ....mos. ....da.

(Signed) [illegible] M. D.

1817 W. Pratt, 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Nov 4, 1920

20-UNDERTAKER Fred Kovach & Son — ADDRESS 1906 Eastland

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47798

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47798

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Preston & Valley Sts. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Matthieu

(a) RESIDENCE. No. Little Sisters of the Poor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about Unknown	65	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

500

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Bartholomew Prochazzk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Victoria —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Sr. Florence

(Address) Preston & Valley Sts.

15 Filed NOV 4 1920 19 G. H. Cress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1920

17 I HEREBY CERTIFY, That I attended deceased from No record, 19 , to , 19 ,

that I last saw her alive on Oct 31, 1920,

and that death occurred, on the date stated above, at 1145 a. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile dementia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. C. Wilbourn, M. D.

Nov 3, 1920 (Address) 1133 Delay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redmer	Nov 5 19
20 UNDERTAKER	ADDRESS
Frank Craddock	906 Carlton Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D47799 HEALTH DEPARTMENT—CITY OF BALTIMORE D47799

CERTIFICATE OF DEATH. X 1

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Theresa Gibbons

(a) RESIDENCE. No. Tangier Island Md ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of T. Gibbons

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt.	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Ella Givens (Address) 3228 Fait Ave.

15 Filed NOV 4 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3rd 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 2nd, 1920, to Nov 3rd, 1920, that I last saw her alive on Nov 3rd, 1920, and that death occurred, on the date stated above, at 4 25 A m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Widal & autopsy

(Signed) J. M. Hundley Jr, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Tangier Island. Va	Nov 4 1920
20 UNDERTAKER Wm Cook	ADDRESS 502 S. Hark Ave

Ration should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 47800

HEALTH DEPARTMENT—CITY OF BALTIMORE

X9-D 47800

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Union Memorial Hospital St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Carey Daniel

(Residence in Baltimore: No. Union Memorial Hospital St.; ..... yrs., ... mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, May (Month) 8 (Day), 1919 (Year)

7-AGE, ... yrs. 1 mos. 2 ds.	If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... W W

9-BIRTHPLACE, (State or Country), South Boston Virginia

PARENTS.

10-NAME OF FATHER, Chas. G. Daniel

11-BIRTHPLACE OF FATHER (State or Country), Kentucky

12-MAIDEN NAME OF MOTHER Susie Hawkins

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles G. Daniel

(Address) South Boston Va.

15- Filed NOV 4 - 1920, 191..... G. H. Grese Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 3, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 25 1920, to Nov 3 1920, that I saw her alive on Nov 3 1920, and that death occurred, on the date stated above, at 8:20 P.m.

The CAUSE OF DEATH* was as follows:

Operation for Cleft Palate

9 days ago.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bedsores for 8 days and Pneumonia (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) A. H. Tammen M. D.

Nov. 3rd, 1920. (Address) Union Memorial Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 10 ds. In the State ..... yrs. ..... mos. 10 ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence South Boston, Va.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
South Boston Va	Nov. 4., 1920
20-UNDERTAKER William Cook	ADDRESS South Boston

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks Broncho - no infection

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, 6 *yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Bks.

D47801

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47801

CERTIFICATE OF DEATH.

100

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 635 Rabory ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Delwood Edwardt Taylor

(Residence in Baltimore: No. 635 Rabory St.: 8 yrs., X mos. X da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Sing

6-DATE OF BIRTH, May 24, 1913 (Month) (Day) (Year)

7-AGE, 7 yrs. 5 mos. 8 da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER Wm H Taylor

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Joyner

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B H Taylor

(Address) 635 Rabory Ave

15-

FILED NOV 4 1920, 191.... G. H. Greco, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 1, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 30 1920 to Nov 1 1920, that I saw h[illegible] alive on Nov 1 1920, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Tonsilitis

(Duration) 0 yrs. 0 mos. 8 da.

CONTRIBUTORY (Secondary) None

(Duration) ... yrs. ... mos. ... da.

(Signed) R. B. Kemp on M. D.

Nov 2, 1920 (Address) 609 W Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	Nov 4, 1920
20-UNDERTAKER	ADDRESS
Daniel Easton	916 Penna Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

144 of 91

D 47802

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91D47802

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 9 WARD)

2-FULL NAME William Bryan.

(a) RESIDENCE. NO. 1521 Lombard St. Baltimore Md. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) and.

PARENTS

10 NAME OF FATHER Leroy Bryan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen Ritter

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant J. Bryan
(Address)

15 Filed NOV 4 - 1920 19 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1920, to Nov. 2, 1920, that I last saw h~~e~~alive on Nov. 2- 1920, and that death occurred, on the date stated above, at 1.50 p. m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) James C. Fox, Jr, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
BALTIMORE CEMETARY.	NOV 4 - 1920 19
20 UNDERTAKER JOHN F. DENNY	ADDRESS 715 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47803

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47803

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2527 Dulaney St. 20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian A. Steffe

(a) RESIDENCE. No. 2527 Dulaney St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? —— yrs. —— mos. —— ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

000

9 BIRTHPLACE (City or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Guy H. Steffe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, md

12 MAIDEN NAME OF MOTHER Nellie Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, md

14 Informant Guy H. Steffe (Address) 2527 Dulaney St

15 Filed NOV 4 - 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3rd 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 31, 1920, to Nov 3, 1920, that I last saw h— alive on Nov 3, 1920, and that death occurred, on the date stated above, at 8 45 a.m.

The CAUSE OF DEATH* was as follows:

Gl's Colitis

Malnutrition

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

Pulmonary Edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert C Nitsch, M. D.

Nov 4 1920 (Address) 2157 Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park cemetery	Nov 4th 1920

20 UNDERTAKER F. D. Nugent ADDRESS 2256 Fredk Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47804

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 47804

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 750 W. Fayette ST.; 4 WARD)

2-FULL NAME Mary A. Karn

(a) RESIDENCE. No. 750 W. Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Reuban L. Karn

6 DATE OF BIRTH (month, day, and year) May 23, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chambersburg Pa

PARENTS

10 NAME OF FATHER James Mc Cartney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Elisa Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Reuban L. Karn
(Address) 750 W. Fayette St

15 Filed NOV 4 - 1920 . 19 3532 C. H. Grace Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 20, 1920, to Nov. 3, 1920, that I last saw her alive on Nov 3, 1920, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Harry Glassman, M. D

. 19 (Address) 1687 Mortens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Nov 5 1920

20 UNDERTAKER Mr. & Mrs. John W. Tenfel — ADDRESS 801 W. Fayette

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPA... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

144108
D47805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D47805

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Simms

(a) RESIDENCE. NO. 1502 Ashland Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Simms

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary C Henry.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant
(Address)

15 Filed ....., 19 .....

NOV 4 - 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1920, to Nov 3 -, 1920, that I last saw h~~im~~ alive on Nov. 3 -, 1920, and that death occurred, on the date stated above, at 1.20 a m.

The CAUSE OF DEATH* was as follows:

Diarrhoea. (not Dysentery)

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	Nov 5 1920
20 UNDERTAKER	ADDRESS
P. B. Gross	1405 McElderry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47806

89 D47806

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1627 W Mulberry ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Debora Taylor

(a) RESIDENCE. No. 1627 W Mulberry WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany 1-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		10 months		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Alex Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Houston Co Ga

12 MAIDEN NAME OF MOTHER Barrie Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Alex Taylor (Address) 1627 W Mulberry St

15 Filed NOV 4 - 1920, 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1920, to Nov 2, 1920, that I last saw her alive on Nov 2, 1920, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Acute Capillary Bronchitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Theo Koerner M. D.

Nov 3, 1920 (Address) 34 So Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Nov 4 1920
20 UNDERTAKER R C Gross.	ADDRESS 1405 Eden ave Edenwald

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47807

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D47807

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2332 Fleet ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank. Szczerbicki

(a) RESIDENCE. No. 2332 Fleet ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of " "

6 DATE OF BIRTH (month, day, and year) Dec 4-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of Industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Frank Szczerbicki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Helena Krusinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Frank Szczerbicki (Address) 2332 Fleet.

15 Filed NOV 4 - 1920 19 Registrar H. H. Grese.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3 1920

17 I HEREBY CERTIFY, That I attended deceased from October 30, 1920, to Nov 3, 1920, that I last saw h— alive on Nov 3, 1920, and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Gastroenteritis

(duration) yrs. Cont. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. A. Farrington, M. D.

Nov 4 1920 (Address) 2431 Fait Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary.	Nov 6 1920
20 UNDERTAKER, W. W. Fallon & Co. 1618 Eastern Ave.	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47808

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47808

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 Rutland Ave ST.; 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis E Champin

(a) RESIDENCE. No. 1001 Rutland Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanch Champin

6 DATE OF BIRTH (month, day, and year) Dec 15

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber 059

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Ambrose Champin

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER E. Courtney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Blanch Champin

(Address) 1001 Rutland Ave

15 Filed NOV 4 - 1920, 19.. G. H. Gress Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 2 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 30, 1920, to Nov 2, 1920, that I last saw h.. alive on Nov 2, 1920 and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage

over

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gastric Ulcer

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Vomiting blood

(Signed) Dr E. Hancock, M. D.

Nov 3, 1920 (Address) 1301 N Rut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Nov 5th 1920
20 UNDERTAKER	ADDRESS
Geo. M. Fink & Son,	511 N Howard St

Funeral Directors & Embalmers.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Carcinoma

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47809

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D47809

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 E. Madison ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Hester Cranston

(a) RESIDENCE. No. 1425 E. Madison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oscar Cranston

6 DATE OF BIRTH (month, day, and year) May 24-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
32	32	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER David H. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Hester Pratt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Rosetta Johnson

(Address) 1425 E Madison St

15 Filed NOV 4 - 1920, 19 C. H. Grebe Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1920, to Nov 1, 1920, that I last saw h alive on Oct 31, 1920, and that death occurred, on the date stated above, at 10:25 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease
General Dropsy with
Paranoic Coma
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) After Influenza
(duration) yrs. 8 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) W. Clyde Burns, M. D.

Nov 2 - 19 20 (Address) 2 L & R Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Country	Nov 4 1920

20 UNDERTAKER Mrs Robt a Elliott ADDRESS 1725 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47810

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47810

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME "Baby" Swaggerman

(a) RESIDENCE. NO. 1101 Dunmore St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant St. Vincent Inf. Asylum
(Address) 401 Dunmore St.

15 Filed NOV 4 - 1920 19 G. H. Grese, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1920.

17 I HEREBY CERTIFY, That I attended deceased from 10/21/ 1920. to 11 1920.
that I last saw him alive on 11/4/ 1920.
and that death occurred, on the date stated above, at 1 30 a m.
The CAUSE OF DEATH* was as follows:

Chronic Intestinal Indigestion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Inanition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goldsborough, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Nov 4 1920

20 UNDERTAKER Martin Kabydon ADDRESS 1011 Park

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47811

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47811

CERTIFICATE OF DEATH.

64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1946 Herbert ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Sealock

(a) RESIDENCE. No. 1946 Herbert ST., 15 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kay Sealock

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
84		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 186

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Warren Va

PARENTS

10 NAME OF FATHER Owen Sealock.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Nancy Sealock (Address) 1946 Herbert St

15 Filed NOV 4 - 1920 G. H. Grese. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23rd, 1920, to Nov-3rd, 1920, that I last saw him alive on Nov-3rd, 1920, and that death occurred, on the date stated above, at 3. A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jones Jones, M. D.

, 19 (Address) 2802 Roslyn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1), Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Comm	Nov. 6 1920
20 UNDERTAKER	ADDRESS
Martin Lahey & Son	1070 North.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47812

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47812

CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 922 Enson ST. Hagerty 10th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Haggerty

(a) RESIDENCE. No. 922 Enson ST., 10th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cate Sleigh Haggerty

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
62	not known		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Not known England

PARENTS

10 NAME OF FATHER Moffitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Catherine Haggerty
(Address) 922 Enson St.

15 Filed ..., 19 ... G. H. Gresse Registrar

NOV 4 – 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 4th 1920

17 I HEREBY CERTIFY, That I attended deceased from July 4th, 1920 to November 2nd 1920 that I last saw h[er] alive on November 2nd, 1920 and that death occurred, on the date stated above, at 5.45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of neck

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) General carcinomatosis (duration) Indefinite ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Slogan, M. D.

. 19 (Address) 7 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Nov. 8 1920
20 UNDERTAKER	ADDRESS
Henry Hoerle Son	1341 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.47813

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47813

CERTIFICATE OF DEATH.

X 109

1-PLACE OF DEATH Womans Hospital

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Lafayette Ave. and John ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alma Mars Halbert

(Residence in Baltimore: No. Towson Maryland St.; 23 yrs., 8 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, January (Month) 23 (Day), 1897 (Year).

7-AGE, 23 yrs. 8 mos. 11 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Registered Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): 048

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry J. Halbert

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Ophelia A. Brown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry J Halbert

(Address) Towson Maryland

15- NOV 4 1920, 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 3 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Oct 16 1920, to Nov. 3 1920, that I saw her alive on Nov 3 1920, and that death occurred, on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction (Duration) .... yrs. .... mos. 19 ds.

(Signed) Herman E Tannenbaum M. D.

Nov 8, 1920. (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 19 ds. In the State 23 yrs. 8 mos. 11 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1806 Eutaw Place,

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery — DATE OF BURIAL, Nov 5th, 1920

20-UNDERTAKER Henry W Mears & Son — ADDRESS 805 N Calvert St

32

Important. See instructions on back of certificate.

D. 47814

CERTIFICATE OF DEATH

64 D. 47814

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. St. Josephs Hosp ST.: 8 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Clark.

(Residence in Baltimore: No. 1618 Broadway St.: 35 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Man

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Not Known (Month) ..... (Day), 1874 (Year)

7 AGE: 46 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Mirror Manufg
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Ireland

PARENTS

10 NAME OF FATHER: Edward Clark

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Emily Walsh

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Jos. C. Clark

(Address): 1618 N. Broadway

NOV 4 - 1920 Filed ....., 191.... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. (Month) 3. (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2, 1920, to Nov 3 1920.

that I saw him alive on Nov 3, 1920, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Duration: ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) 24 hrs. Duration: ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Riley M. D.

Nov. 3, 1920 (Address) 1632 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Forest Arbor, N. J. DATE OF BURIAL: Nov. 5, 1920

20 UNDERTAKER: E. D. Fanning & Son ADDRESS: 1930 E Lafayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 47815 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 47815

CERTIFICATE OF DEATH.

92 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 N. Bary St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Sisselberger

(a) RESIDENCE. No. 923 N Bary St. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 29 1850

7 AGE: Years 70+ Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Louis Sisselberger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Carline M Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Carrie A Brooks (Address) 923 N Bary St

15 Filed NOV 4 - 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29th, 1920, to Nov. 2, 1920, that I last saw h[er] alive on Nov. 2, 1920, and that death occurred, on the date stated above, at 2 30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2-3 ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation 4 hours

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Israel J. Kringle, M. D.

Nov 3, 1920 (Address) 2006 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet — DATE OF BURIAL: Nov 5 1920

20 UNDERTAKER: Wm Lee — ADDRESS: 502 E Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047816

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047816

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged men + women's Home ST. 4th (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sarah Larkins

(a) RESIDENCE. No. 1622 Druid Hill Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Emma Brown

(Address) 1622 Druid Hill

15 Filed NOV 5 - 1920 ROBERT F. KRAUTER Registrar

Burial Permit Oleek

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1920, to Nov. 3, 1920, that I last saw her alive on Nov. 3, 1920 and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Edw. J. Wheatley, M. D.

11/3, 1920 (Address) 1230 Dillon ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 5 1920
20 UNDERTAKER	ADDRESS
John H. Bradenbaugh	142 Mulberry St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D47817

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47817

CERTIFICATE OF DEATH.

175-003

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. E & O Coal pier Curtis Bay DIST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Furrell. (C)

(Residence in Baltimore: No. 1001 E. Howard St. St.; yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH, Do not know. (Month), 1 (Day) (Year)

7-AGE,	If LESS than 1 day,
45 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Kanesville, Va.

PARENTS.

10-NAME OF FATHER, Steet Furrell. (C)

11-BIRTHPLACE OF FATHER (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER Harriett Wallace. (C)

13-BIRTHPLACE OF MOTHER (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob Furrell. (C) brother.

(Address) 911 Pierce St.

15-Filed NOV 5 - 1920 191 ROBERT E KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 1st. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Run over and mangled by E & O R.R. Co. coal car.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto Reinhardt M. D. (Coroner.)

Nov. 4th, 1920. (Address) 1017 E. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Nov 5 1920
20-UNDERTAKER Daniel Easton	ADDRESS 916 Pa ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47818

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47818

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 64 S. Conkling ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Romaine Ambrose

(a) RESIDENCE. NO. 64 S. Conkling ST., 6 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 17 th 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Reisterstown Md

PARENTS

10 NAME OF FATHER Geo H. Ambrose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Reisterstown Md.

12 MAIDEN NAME OF MOTHER Alverta Ambrose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Reisterstown Md

14 Informant Geo H. Ambrose

(Address) 64 S Conkling

Filed NOV 5 - 1920 ROBERT E KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 1920

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to Nov. 2, 1920, that I last saw her alive on Sept 30 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Enter- Colonitis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Intussusception

(duration) yrs. one mos. ds.

18 Where was disease contracted if not at place of death? Reisterstown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sy. & Surg. Symp.

(Signed) G. G. Klein, M. D.

, 19 (Address) 1301 N. Chas. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Reisterstown Md

DATE OF BURIAL: 11/5 1920

20 UNDERTAKER: J. J. Moran

ADDRESS 900 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary Tuberculosis.
Then developed tuberculous
entero colitis.

Poebel.

1047819 HEALTH DEPARTMENT—CITY OF BALTIMORE 64 #7819

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 714 Eastern Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Rappel

(Residence in Baltimore: No. 402 S Patterson Park Ave St.) (yrs. 6) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May 8, 1864
(Month) (Day) (Year)

7-AGE, 5 yrs. 7 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Saloon 040
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, John Rappel

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Mary Lasicka

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Rappel

(Address) 402 S Patterson Park

15- NOV 5 1920 ROBERT B KRAUSER

Filed ..... 191..... Burial Permit Issued Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 3, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest also (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) investigation find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Edward J. Gruber M. D.
(Coroner.)

Oct 4, 1920. (Address) 1801 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Nov 6, 1920
20-UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D47820 — 42 — D47820

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 S Ann St ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Kowalewska

(a) RESIDENCE. No. 503 S Ann St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John Kowalewski

6 DATE OF BIRTH (month, day, and year) Oct 30 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER unknow

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Helen Pika

(Address) 923 S Regester

15 Nov 5 1920 ROBERT T. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug ..., 1920, to Nov 3, 1920, that I last saw h[illegible] alive on Nov 3 1920, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(duration) yrs. 3 mos. ds.

CONTRIBUTORY —

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. Walentowicz, M. D.

Nov 7, 1920 (Address) 822 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov 6 1920
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

IMPORTANT—This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1047821 HEALTH DEPARTMENT--CITY OF BALTIMORE 1047821

CERTIFICATE OF DEATH

104

1 PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 821 Montford Av. ST. 1 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Louis Hennick

(Residence in Baltimore: No. 821 Montford Av. St.; yrs. 4 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~SINGLE, MARRIED, WIDOWED OR DIVORCED~~ (Write the word): Single

6 DATE OF BIRTH: July (Month) 3 (Day), 1920 (Year)

7 AGE: yrs. 4 mos. 1 ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Louis Hennick.

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Plaige. Murdock.

13 BIRTHPLACE OF MOTHER (State or country): Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Hennick

(Address) 821 Montford Av,

15 NOV 5 - 1920 — ROBERT B KRAUTER — Burial Permit Clerk (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov (Month) 4 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2, 1920, to Nov 4 1920, that I saw h~~im~~ alive on Nov 2, 1920, and that death occurred, on the date stated above, at 9 a m.
The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) yrs. mos. about 4 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) John Chatwick M. D.

Nov 4, 1920 (Address) 11 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Rosary — DATE OF BURIAL: Nov 5 1920

20 UNDERTAKER: John R Weber — ADDRESS: 1803 Bank St

Spec.—8-24-14—M. & T.—2000 Bks.

Ray

HEALTH DEPARTMENT—CITY OF BALTIMORE

047822 — 28 — 047822

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 47 Arquith ST.: 5 WARD)

(If death occurred in a hospital or institution, give Its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME William H. Ray

(Residence in Baltimore: No. 47 Arquith St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	col.	married

6-DATE OF BIRTH, Sept 10, 1879 (Month) (Day) (Year)

7-AGE, 41 yrs. 1 mos. 22 ds. If LESS than 1 day, ~~hrs. or~~ min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

9-BIRTHPLACE, (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Ray

(Address) 47 Arquith St

15- Filed NOV 5 - 1920 ROBERT E KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 2, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1920, to ~~1920~~, that I saw him alive on Nov 1 1920, and that death occurred, on the date stated above, at 4.45 a.m.

The CAUSE OF DEATH* was as follows:

Probable Pulmonary Tuberculosis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure Sudden

(Duration) yrs. mos. ds.

(Signed) Wakefield Boyle M. D.

Nov 2, 1920 (Address) 725 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. | DATE OF BURIAL, Nov 5, 1920

20-UNDERTAKER Chas. H. Johnson | ADDRESS 716 N. Caroline

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

947823

HEALTH DEPARTMENT—CITY OF BALTIMORE

947823

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 Faith lane ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Smith

(a) RESIDENCE. NO. 1621 Faith lane ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (~~write the word~~): married

5a If married, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of: John E. Smith

6 DATE OF BIRTH (month, day, and year): May 1, 1886

7 AGE: Years 34 Months 6 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED: at home

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Slivecky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: John E. Smith

(Address): 1621 Faith lane

15 FILED NOV 5 - 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 3 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept - 1920, to Nov 3 1920, that I last saw her alive on Nov 2 1920, and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? I don't know

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) W H Sage, M. D.

, 19 (Address) 709 N Bdway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Vincents De Paul — DATE OF BURIAL: Nov 6 1920

20 UNDERTAKER: Zirkler & Zirkler — ADDRESS: 1739 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047824 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047824

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Queaney

(a) RESIDENCE. NO. 1119 Keyser ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 9 1919

7 AGE Years 11 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Albert Dempsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Marie Earl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Hospital Record
(Address) J. H. H.

15 Filed NOV 5 - 1920 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 4th, 1920, to Nov 4th, 1920, that I last saw her alive on Nov 4th, 1920, and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) James E. Fox Jr., M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Halethead City — DATE OF BURIAL: Nov 6 1920

20 UNDERTAKER: Robt J. Turner Inc — ADDRESS: 1X4L Y Bway

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Intestinal Indigestion

D47825 Tuer. HEALTH DEPARTMENT—CITY OF BALTIMORE D47825

CERTIFICATE OF DEATH.

56

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 220 Augusta St.: 5 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene Tuer

(Residence in Baltimore: No. 220 Augusta St.: 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Divorced

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 47 yrs. 2 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Thomas Tuer

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Reb. Drake

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benj. Drake

(Address) 1626 Bradd

15- FILED NOV 5 - 1920 ROBERT B KRAUTER Registrar Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 3, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the dny stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism
Heart Failure (Duration) 2 days

CONTRIBUTORY.....
(Secondary)
(Duration) ....yrs....mos....ds.

(Signed) Murray (Coroner.) M. D.

Nov 5, 1920 (Address) 165 E Lay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery

DATE OF BURIAL, Nov. 6th, 1920

20-UNDERTAKER George Schilling & Sons

ADDRESS 1126 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

J. H. Riemer Diggs

D47826

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47826

CERTIFICATE OF DEATH.

175-001

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. On Mayor at Mercy Hospital ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J. H. Diggs (Diggs)

(Residence in Baltimore: No. 2101 Erdman Ave.

20 St.; yrs., 1 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single (W. J.R.)

6-DATE OF BIRTH, Sept (Month) 8 (Day), 1900 (Year)

7-AGE, 20 yrs. 1 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ~~Laborer~~ W.T.R.
(b) General nature of industry, business, or establishment in which employed (or employer) Electrician

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm. J.B. Diggs

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Katie Kramer

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. J.B. Diggs

(Address) 2101 Erdman

15-

Filed NOV 5 - 1920 ROBERT E. KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 3 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.), thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Injuries (Prob. Hemorrhage) Abdomen
Accidentally Struck by Auto truck
Sudden (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)
.....(Duration).....yrs.....mos.....ds.

(Signed) W. Wiley M. D.
(Coroner.)
Nov 3, 1920 (Address) 1607 E. Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	Nov. 6th, 1920
20-UNDERTAKER	ADDRESS
George Schulling & Sons	1126 Eutaw Place

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047827 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047827

CERTIFICATE OF DEATH. 42

1-PLACE OF DEATH Confederate Womans Home REGISTERED NO.

CITY OF BALTIMORE: (No. 1020 Linden Ave ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josie Bales.

(a) RESIDENCE. No. 1020 Linden Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Female	White	Widowed

5a If married, ~~widowed~~ or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of J K Bales.

6 DATE OF BIRTH (month, day, and year) Feb 14 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	71	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Confederate 000

(b) General nature of industry, business, or establishment in which employed (or employer) Womans Home

(c) ~~Name of employer~~

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER Felix Grundy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Susan Dunke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Mrs. Wilson
(Address) 403 N Front St

15 FILED NOV 5 - 1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/4 1920

17 I HEREBY CERTIFY, That I attended deceased from 10/29 1920, to 11/4 1920, that I last saw her alive on 11/3 1920, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Ca. Carcinomatosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Uterus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) J J Waine M. D.

. 19 (Address) 1939 W Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem DATE OF BURIAL Nov 6 1920

20 UNDERTAKER Henry W Jenkins & Sons Co Mc=Coll ADDRESS Orchard

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047828 HEALTH DEPARTMENT—CITY OF BALTIMORE 047828

CERTIFICATE OF DEATH. X 41

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Nicholas

(a) RESIDENCE. No. Church Home & Infirmary ST., WARD. Baltimore

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Wht.	Single

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) June 6 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Mr. Nicholas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant P. S Watts Attorney

(Address) 222 E Baltimore St

15 Filed NOV 5 – 1920 19 ROBERT P. LAMOND Registrar

Burial Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1 1920 to Nov. 4 1920

that I last saw her alive on Nov. 4 1920

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma Duodenum

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Idiopathic

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? The exam.

(Signed) Hilbert M. D

. 19 (Address) Church Home Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Nov 5 1920
20 UNDERTAKER	ADDRESS
Henry H Jenkins Son & Co	Oakland Mt Holly

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047829 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047829

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St.: 9 Ward) REGISTERED NO. 29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephs Friedrich

(a) RESIDENCE. No. St. Josephs Hospital St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 20 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	80	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Joseph Friedrich
(Address) 31 & Falls Road

15 Filed NOV 5 - 1920 19... ROBERT E LEANTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 1920

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1920, to Nov 4, 1920, that I last saw h.. alive on Nov. 4, 1920, and that death occurred, on the date stated above, at 4 20 P m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis C Marine, M. D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Nov. 6 1920
20 UNDERTAKER	ADDRESS
Haney & Hosch Inc	1301 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU... TION is very important. See instructions on back of certificates.

1047830 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047830

CERTIFICATE OF DEATH.

103

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 513 Hargrove Rd ST.; 11 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill but No. 18.)

2-FULL NAME Walter Stanley

(Residence in Baltimore: No. 513 Hargrove Rd St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, November, 1881
(Month) (Day) (Year)

7-AGE 39 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Shoe polisher,
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Doby Stanley

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Annie Stanley

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Smith

(Address) 513 Hargrove St

15- Filed NOV 5 - 1920, 191.. ROBERT B KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 2, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute indigestion

Sudden (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

Nov 3, 1920 (Address) 103 Lee

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt Auburn

DATE OF BURIAL, Nov 12 1920

20-UNDERTAKER Samuel Stanley

ADDRESS 3 Bolton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Robert J. Garrison

D47831 HEALTH DEPARTMENT—CITY OF BALTIMORE. D47831

CERTIFICATE OF DEATH.

X 115

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Union Memorial Hospital St., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert J. Garrison

(Residence in Baltimore: No. Union Memorial Hospital St.; ....yrs., 1 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, June 29, 1875
(Month) (Day) (Year)

7-AGE, 45 yrs. 4 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fruit grower
(b) General nature of industry, business, or establishment in which employed (or employer): 186

9-BIRTHPLACE, (State or Country), Brookfield Penn—

PARENTS.

10-NAME OF FATHER, John Garrison—

11-BIRTHPLACE OF FATHER (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER, Mary Thompson

13-BIRTHPLACE OF MOTHER (State or Country), Penn—

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary R. Garrison

(Address) Judson Florida

15-

Filed NOV 5 - 1920 ROBERT B KRAUTER Del.....

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov-4, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct-1 1920, to Nov 4 1920, that I saw him alive on Nov 4 1920, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation with pulmonary edema

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Exploratory operation

Hepatitis (Duration) 3 yrs. ....mos. ....ds.

(Signed) L. H. Hammerbacher M. D.

Nov 4, 1920. (Address) Union Memorial Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 28 ds. In the State ....yrs. ....mos. 28 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Jensen Fla.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Brookville Pa	Nov 6, 1920

20-UNDERTAKER	ADDRESS
John Connecticut	Baltimore

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47832

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47832

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1911 E. Pratt St. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Stolotz

(a) RESIDENCE. No. 1911 E. Pratt St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Oct. 18-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. md.

PARENTS

10 NAME OF FATHER Daniel Zimmerman

11 BIRTHPLACE OF FATHER (city or town) ~~Balto~~ (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Arnold G. Stolotz

(Address) 1911 E. Pratt st.

15 Filed NOV 5 - 1920, 19.. ROBERT E. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 27, 1920, to Nov 8, 1920,

that I last saw h[illegible] alive on Nov 3, 1920

and that death occurred, on the date stated above, at 9.40 a. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

Chronic Nephritis (duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Ca. duodenum

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyle, M. D.

Nov 5 19 (Address) 612 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Nov. 6 1920
20 UNDERTAKER Lilly and Zeiler	ADDRESS 403 S. Wolfe

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47833

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79 D47833

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 Trinity St. St.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sebastian Scandora

(a) RESIDENCE. No. 913 Trinity St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs 4 mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francesca Scandora.

6 DATE OF BIRTH (month, day, and year) April 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	6		

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Iron worker.

(b) General nature of industry, business, or establishment in which employed (or employer) Bartlett-Hayward Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Riposto Italy.

PARENTS

10 NAME OF FATHER Mariano Scandora.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Riposto. Italy.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Riposto Italy.

14 Informant Francesco Scandora
(Address) 913 Trinity St.

15 NOV 5 - 1920 ROBERT B. LAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2nd 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1920, to Nov 2, 1920, that I last saw h— alive on Nov 1, 2, 1920, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Cardiac Disease

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. Wheelan, M. D.

(Address) #2 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Nov. 6 1920
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Mo. Ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 47834

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 47834

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 1 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Schreib.

(Residence in Baltimore: No. 318 S. Madeira St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, December 25, 1869 (Month) (Day) (Year)

7-AGE, 50 yrs. 10 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER. Frederick Krebs

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond Schreib

(Address) 318 S. Madeira St.

15-

Filed NOV 5 - 1920, 191... ROBERT E. KRAUTER... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 3 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 1 1920, to November 3 1920, that I saw her alive on November 2 1920, and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

Bronchopneumonia

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 5 ds.

(Signed) Manuel B. Zieber M. D.

Nov. 3, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 318 S Madeira St

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cem. DATE OF BURIAL, Nov. 6, 1920

20-UNDERTAKER Lilly and Zieber ADDRESS 1103 S Wolfe St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47835 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47835

CERTIFICATE OF DEATH. 115

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Jarvey Road Farm Park Estate St.; 2nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME S. Hammond Nidley

(Residence in Baltimore: No. Jarvey Road. St.; 70 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Apr. 23, 1850 (Month) (Day) (Year)

7-AGE, 70 yrs. 6 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John M. Nidley

11-BIRTHPLACE OF FATHER (State or Country) Balto Co Md

12-MAIDEN NAME OF MOTHER Sarah Richards

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. Prescott Webb

(Address) Jarvey Road

15-

Filed ..... 191.....

Robert P. Harrison,
Registrar.

NOV 5 - 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 5, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1920, to Nov 5 1920, that I saw him alive on Nov 4 1920, and that death occurred, on the date stated above, at 12 30 a.m.

The CAUSE OF DEATH* was as follows:

.....

Toxaemia

.....

..... (Duration).....yrs.....mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic nephritis? (Inspection) See remarks.

..... (Duration).....yrs.....mos. 4 ds.

(Signed) M Hammond Hood M. D.

Nov 5, 1920. (Address) 626 N. Gilmor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cemetery | DATE OF BURIAL, Nov 6, 1920

20-UNDERTAKER Edward J. Smith | ADDRESS 25 Gilmor St.

Important. See instructions on back of certificate. (over)

D.47836 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47836

CERTIFICATE OF DEATH.

REGISTERED No. C 172-092

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital St. 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Burnett.

(Residence in Baltimore: No. 15 Pearl St.) 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Don't Know ..... (Month) ..... (Day), 1 ..... (Year)

7-AGE. abt 30 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Sheet Metal Worker
(b) General nature of industry, business, or establishment in which employed (or employer). Sheet Metal Worker

9-BIRTHPLACE, (State or Country). S. Carolina

PARENTS.

10-NAME OF FATHER. Perry Burnett

11-BIRTHPLACE OF FATHER (State or Country). S C.

12-MAIDEN NAME OF MOTHER. Mattie Hampton.

13-BIRTHPLACE OF MOTHER (State or Country). S C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. T. Brown

(Address) Glendale S C

15- Robert P. Harrison,

Filed ....., 191.....

NOV 5 - 1920 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 4-, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tobacco Amblyopia
Hosiery Spotting from Scarlet & Grey Dyes Patient Married.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Nov 5, 1920 (Address) 16 E Pleasant

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death 8 days yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Spartanburg S. C.	Nov. 5, 1920
20-UNDERTAKER William Cook	ADDRESS 502 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

20.47837

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.47837

CERTIFICATE OF DEATH.

154

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 712 n Duncan ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin Leis.

(Residence in Baltimore: No. 712 n Duncan St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, wht.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dont Know, 1 .....
(Month) (Day) (Year)

7-AGE. 81 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION.
(a) Trade, profession, or particular kind of work: Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer): Maker

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth V. Ruhwan

(Address) 1009 Roland ave

15-

Filed NOV 5 1920, 191.....

Robert P. Harrison, Registrar.
~~Burial Permit Clerk.~~

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Nov. 4, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injured by picture
Shot
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Chas. Gundy M. D.
(Coroner.)
11-4-20 191. (Address) 1 E Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Nov 6, 1920

20-UNDERTAKER William Cook — ADDRESS 502 N North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 5 1920

D.47838 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47838

Annie Thomas

CERTIFICATE OF DEATH.

79

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 18 W. Church St. St.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Onnie Thomas. (C)

(Residence in Baltimore: No. 18 W. Church St. St.: 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Married

6-DATE OF BIRTH. do not know., (Month) (Day) 1 (Year)

7-AGE.	If LESS than 1 day,
44 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None. 031
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Calvert Co. Md.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James A. Banks. (C)

(Address) 18 W. Church St.

15- Robert P. Harrison,
Filed NOV 6 1920, 191
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 4th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

Nov 4th, 1920. (Address) 10 W. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Nov 6 1920
20-UNDERTAKER John H. Toadvine	ADDRESS 1417 W Fayette St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47839 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47839

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 727 Wasche ST.; 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Woody

(a) RESIDENCE. No. 727 Wasche ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 3 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 28-1906

7 AGE: Years 14; Months 3; Days 8; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Benj Wood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Harper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Wood

(Address) 727 Wasche St

15 Filed 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1920 to Nov 3 1920

that I last saw h[illegible] alive on Nov 3 1920

and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Health Dept

(Signed) S B Hughes M. D.

(Address) 1413 E. Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Md Auburn Cmty	Nov 6 1920
20 UNDERTAKER	ADDRESS
Geo H. Holland	1631 Aisquith

Hilland

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- at it may be properly classified. Use plain terms, so that it

Spec.—8-24-14—M. & T.—2000 Bks.

D.47840 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47840

CERTIFICATE OF DEATH.

120 REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1226 N Charles ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H Broesel

Residence in Baltimore: No. 1226 N Charles St.; 60 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, March (Month) 15 (Day) 1850 (Year)

7-AGE, 50 yrs. 7 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country) Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Louisa Semple

(Address) 1226 N Charles St.

15- Filed ..... 1920 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 4 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 11 1920, to Nov 4 1920, that I saw him alive on Nov 4 1920, and that death occurred, on the date stated above, at 1A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

..... (Duration) ..... yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) August Koon M. D.

Nov 5, 1920 (Address) 40 E 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park DATE OF BURIAL, Nov 6, 1920

20-UNDERTAKER Harry A. Witzke ADDRESS 1531 W Lombard

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 47841

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 47841

CERTIFICATE OF DEATH.

103

1-PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE: (No. Main & orchard St ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 16.)

2-FULL NAME Wm Wolf

(Residence in Baltimore: No. Main & orchard St Mt Winans St.: 49 yrs. 11 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W	Married

6-DATE OF BIRTH, 11 (Month) 29 (Day), 1870 (Year)

7-AGE.	If LESS than 1 day,
49 yrs. 11 mos. 26 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Grocer Packer
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, August Wolf

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Elizabeth Knickmon

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Louise Wolf

(Address) Main & Orchard Sts Mt Winans

15- NOV 6 1920 Robert P. Harrison, 191.....
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 3 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from .....191...., to Nov 3 1920, that I saw h..... alive on .....191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Acute indigestion
Was dead when arrived
about 1 hour
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)
(Duration).....yrs.....mos.....ds.

(Signed) Wm B Hall M. D.
11-4-, 1920 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violence, state the MEANS OF INJURY; and whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cem	Nov 6, 1920

20-UNDERTAKER	ADDRESS
John F Cowan & Son	901 Baltimore St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47842 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47842

CERTIFICATE OF DEATH.

91

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1232 Gilmor ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L. Queen

(Residence in Baltimore: No. 1232 Gilmor St.; 11 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Infant

6-DATE OF BIRTH, Nov. (Month) 25 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
....yrs. 7 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work — 000
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Balto. City Md.

PARENTS.

10-NAME OF FATHER, Irish Queen

11-BIRTHPLACE OF FATHER (State or Country), Balto. City Md.

12-MAIDEN NAME OF MOTHER Daisy Simmons

13-BIRTHPLACE OF MOTHER (State or Country), Balto. City Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Queen

(Address) 723 N. Gilmor St.

15- NOV 6 - 1920 Robert P. Harrison,
Filed....., 191.....
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 3 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 3 1920, to Nov 3 - 1920, that I saw him alive on Nov 3 - 1920, and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ...yrs. ...mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) Thos. L. McCarthy M. D.

Nov. 4 -, 1920 (Address) 906 N. Strieker St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Nov. 6..., 1920
20-UNDERTAKER JAMES H. DENNIS	ADDRESS 1303 PRESTMAN ST.

Instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 47843 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 47843

10-061

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmine Ehrhardt

(a) RESIDENCE. NO. 336 E 15th St Baltimore WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single -

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 25 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		12	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER O. C. Ehrhardt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ohio

12 MAIDEN NAME OF MOTHER Harriet Thomas

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Johns Hopkins Hospital
(Address)

15 Filed NOV 6 - 1920 Robert P. Harrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1920, to Nov 5, 1920, that I last saw h alive on Nov 5, 1920, and that death occurred, on the date stated above, at 1 A.M. m.

The CAUSE OF DEATH* was as follows:

Meningitis, (B. influenzae)

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY —
(Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 336 E. 15th

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Lumbar puncture + Culture

(Signed) W. Brown, M. D.

, 19 (Address) J. H. H. Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Nov 7 1920
20 UNDERTAKER H. Sander Sons	ADDRESS 120 Balto

'TION is very important. See instructions on back of certificates. ...may be properly classified. ...exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Influenza & meningitis

Spec.—8-24-14—M. & T.—2000 Bks.

D.47844 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47844

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 345 Stinson ST.; 20 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John E Sipes. Jr

(Residence in Baltimore: No. 345 Stinson St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Single

6-DATE OF BIRTH, Nov 1, 1920 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs....mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John E Sipes

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Nannie Nice

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E. Sipes

(Address) 345 Stinson St.

15- NOV 6 - 1920 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 5, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1920, to Nov 5 1920, that I saw him alive on Nov 5 1920, and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Premature

Birth

(Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Premature Birth

(Duration) ....yrs.....mos.....ds.

(Signed) Robert P Shipley M. D.

Nov 6, 1920 (Address) 2151 Baltimore Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cathedral — DATE OF BURIAL, Nov 6, 1920

20-UNDERTAKER Edward P Conklin — ADDRESS 127 E Fayette

Important: See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47845

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 37

D47845

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Maryland Gnseral Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Daley.

(a) RESIDENCE. NO. Manchester Conn. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
58				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Trainin g Race Horses.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer (over)

9 BIRTHPLACE (city or town) (State or country) Ont Ireland

PARENTS

10 NAME OF FATHER Joseph Daley

11 BIRTHPLACE OF FATHER (city or town) (State or country) County Cork Ireland

12 MAIDEN NAME OF MOTHER Mary Barry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dublin Ireland

14 Informant Hospital Record.
(Address)

15 Filed NOV 6 - 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 6 1920.

17 I HEREBY CERTIFY, That I attended deceased from October 23. 1920. to November 6. 1920., that I last saw him alive on November 6. 1920., and that death occurred, on the date stated above, at 9.00 A. m.

The CAUSE OF DEATH* was as follows:

OVER

Aortic Aneurysm
Typhoid Fever (?)

(duration) (?) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Rupture of Aneurism.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? d

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam & Laboratory

(Signed) C. Wilbur Stewart. M. D.

11/6. 1920 (Address) Maryland Gnseral Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Manchester Conn.	Nov 7 1920
20 UNDERTAKER	ADDRESS
E & B Hale	115 E Madison

THION is very important. See instructions on back of certificates. may be properly classified. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

(Data obtained from Miss Fox at the Md. General Hospt.

See Dr. Stewart's letter.

(Not typhoid. Syphilis.)

20.47846

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.47846

CERTIFICATE OF DEATH.

156

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 628 Hanover St. St. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Egnot Bogatuke.

(Residence in Baltimore: No. 628 Hanover St. St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH, Do not know., 1 (Month) (Day) (Year)

7-AGE, 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Report.

(Address)

15- Robert F. Harrison,

Filed NOV 5 1920, 191

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 28th, 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating gas poisoning.
Suicide.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto K. Eenhardt, M.D. (Coroner.)

Nov. 5th., 1920. (Address) 1017 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, 19
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL NOV 5 1920

Commissioner of Health,

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

14393
D. 47847

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 47847

CERTIFICATE OF DEATH.

X 37

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Dillon.

(a) RESIDENCE. No. Winston Salem N.C. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2. 882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 40

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Major Dillon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucia O'Neal.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant (Address) J. Hutt.

15 Filed NOV 6 1920 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1920, to Nov. 2, 1920, that I last saw him alive on Nov. 2, 1920, and that death occurred, on the date stated above, at 2.50 a. m.

The CAUSE OF DEATH* was as follows: Over

Cerebral Oedema (Post Operative)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. A. Mason, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS

NOV 6 - 1920

Burial Permit Clerk.

TION is very important. See instructions on back of certificates. ...statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Removal Rt. cortical motor arm area.
(Hemiplegia?)
Probably Lactic

Spec.—8-24-14—M. & T.—2000 Bks.

D.47848

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47848

CERTIFICATE OF DEATH.

151

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1232 Riverside ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Marley

(Residence in Baltimore: No. 1232 Riverside St Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	

6-DATE OF BIRTH, Oct 29 (Month) (Day), 1920 (Year)

7-AGE, ...yrs. ....mos. 8 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, John Marley

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A. Marley

(Address) 1232 Riverside Ave

15- Nov 6 1920, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 6 (Month) (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29 1920, to Nov. 6 1920, that I saw h er alive on Nov. 5 1920, and that death occurred, on the date stated above, at 4 4 m.

The CAUSE OF DEATH* was as follows:

Bronchitis

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) A. Bellmeyer M. D.

Nov 7, 1920 (Address) 1232 Riverside Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross R.C. Co	Nov 7, 191..
20-UNDERTAKER William Cook	ADDRESS 503 E Hall ave

Fill out all questions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 47849 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 47849

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1726 Friendsbury ST.; 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Ida Wilkie

(a) RESIDENCE. No. 1726 Friendsbury ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H. Wilkie

6 DATE OF BIRTH (month, day, and year) Feb. 23 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Freedom Pa

PARENTS

10 NAME OF FATHER Daniel Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Sarah Hershey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Wm H. Wilkie

(Address) 1726 Friendsbury

15 Filed NOV 6 - 1920 19 Robert P. Harris Registrar

Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1920

17 I HEREBY CERTIFY, That I attended deceased from ——, 1915, to Nov. 5th, 1920.

that I last saw her alive on Nov. 5th, 1920.

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows: Endothelioma of base of brain, ascertained by X-rays

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Paralysis

(duration) 1 to 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? About 5 yrs. ago.

Was there an autopsy?

What test confirmed diagnosis? X-rays & paralysis.

(Signed) O. H. Hoffman, M. D.

19 (Address) 2100 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Freedom Pa	Nov 7 1920
20 UNDERTAKER	ADDRESS
Wm J. Tickner & Sons	North Ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47850 D.47850

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1/120

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 2130 N. Fulton St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa A. J. Burnham.

(Residence in Baltimore: No. 2130 N. Fulton Ave St.; 62 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.) Widowed

6-DATE OF BIRTH, September (Month) 30 (Day), 1858 (Year)

7-AGE, 62 yrs. 1 mos. 4 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Work
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George Crowe McCabe

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Rose A. Vernon

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harold Stevens

(Address) 2120 N. Fulton ave.

15-

NOV 6 - 1920

Robert P. Harrison, M.D.
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 5 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from July 21 1920, to Nov 5 1920, that I saw her alive on Nov 5 1920, and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Uraemic Coma ~~and Chronic~~

Interstitial Nephritis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 4 yrs. 0 mos. ds.

(Signed) H. Sherwood Shelley M. D.

Nov 5, 1920 (Address) 2349 Reisterstown Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Nov 8, 1920

20-UNDERTAKER W. J. Talbert — ADDRESS North Ave

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47851 HEALTH DEPARTMENT—CITY OF BALTIMORE D47851

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 Cathedral St.: 11 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Nelson.

(a) RESIDENCE. No. 402 Cathedral St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Nelson

6 DATE OF BIRTH (month, day, and year) May 5-1864

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
56	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housekeeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John Nelson (Address) 402 Cathedral St

15 NOV 7-1920 ROBERT E KRAUT Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1920, to Nov. 5, 1920, that I last saw h[illegible] alive on Nov. 5, 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Coma.

(duration) yrs. mos. 14 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Trommers & Diamond

(Signed) W. J. Carr Jr., M. D.

Nov. 6 1920 (Address) 515 Mosher St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Cemetery	Nov 8 1920

20 UNDERTAKER George H. Holland ADDRESS 1631 Eutaw Pl

Hld Carr

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

647852 — 79 — 647852

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 E Federal ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Abraham Mack.

(a) RESIDENCE. NO. 1710 E Federal ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Betty Mack

6 DATE OF BIRTH (month, day, and year) Aug. 27 - 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigarmaker 617

(b) General nature of industry, business, or establishment in which employed (or employer) Mfg cigars

(c) Name of employer Himself

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Abraham Mack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Fiedler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Betty Mack
(Address) 1710 Federal St

15 NOV 7 - 1920

ROBERT I. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 4 1920 to Nov 4 1920

that I last saw him alive on Nov 4 1920

and that death occurred, on the date stated above, at 3.30 A.M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) Abt 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo Fearing M. D.

19 (Address) 1107 Fenwick Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Nov. 7 1920
20 UNDERTAKER H. M. Cook	ADDRESS H & G Mkt.

THIS IS very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

0478 53

HEALTH DEPARTMENT—CITY OF BALTIMORE

0478 53

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Hermana Wietz

(Residence in Baltimore: No. Chiquith St & Ashland Ave St.; 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, January (Month) 17 (Day), 1843 (Year)

7-AGE,	If LESS than 1 day,
77 yrs. 9 mos. 19 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Teacher 165
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Wietz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Hacker

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister M. Dismas

(Address) Notre Dame Chiquith St

15-

Filed NOV 7 1920, 191.....

ROBERT B KRAUTER
Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 5 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 3 191..., to Nov 5 1920, that I saw h.. alive on Nov 4 1920, and that death occurred, on the date stated above, at 2.10 p.m.

The CAUSE OF DEATH* was as follows:

Left Bronchopneumonia

(Duration) ...yrs. ...mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ...yrs. ...mos. ...ds.

(Signed) F. J. Kelly M. D.

Nov 5 1920 (Address) 1108 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Notch Cliff Md.	Nov 8, 1920
20-UNDERTAKER	ADDRESS
Frank A. Fink	915 N. Gay St

Spec.—8-24-14—M. & T.—2000 Bks.

1047854 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047854

CERTIFICATE OF DEATH.

92

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Nicetas Rossbach

(Residence in Baltimore: No. Virginia St and Cathedral Ave St.; 15 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR ~~DIVORCED~~, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, August (Month) 15 (Day), 1849 (Year)

7-AGE,	If LESS than 1 day,
71 yrs. 2 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Philipp Rossbach

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Edler

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Mary Dismas

(Address) Notre Dame Virginia St

15- Filed NOV 7 1920 ROBERT B KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 5 (Month) (Day), 1920. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 31 1920, to Nov 5 1920, that I saw her alive on " 4 1920, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

Exp Acute

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F J Kelly M. D.

Nov 5, 1920 (Address) 110 E Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Notch Cliff Md	Nov 8, 1920
20-UNDERTAKER	**ADDRESS**
Frank A. Fink	905 N. Gay St

Spec.—6-9-19—H. P. Co.—1000 Blks.

1947855 HEALTH DEPARTMENT—CITY OF BALTIMORE 1947855

DAVIS CERTIFICATE OF DEATH. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3905 E. Lombard ST.: 76 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Davis

(a) RESIDENCE. No. 3905 E. Lombard ST., 76 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 26 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None yet

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City.

PARENTS

10 NAME OF FATHER Samuel Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Cornelia Finn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Samuel Davis.
(Address) 3905 E. Lombard St.

15 Filed NOV 7-1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1920, to Nov 6, 1920, that I last saw him alive on Nov 5, 1920, and that death occurred, on the date stated above, at 8:45 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Lobular Pneumonia

(duration) X yrs. X mos. 2 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jno R Grimes, M. D.

19 (Address) 2485 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary Cemetery	Nov. 9 1920
20 UNDERTAKER	ADDRESS
Lilly & Fidler	403 S. Mo[illegible]

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

1342

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47856

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47856

CERTIFICATE OF DEATH.

120-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Roland Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Jane Cooper

(a) RESIDENCE. No. 2 Roland Av ST., WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 0 mos. 16 ds. How long in U. S., if of foreign birth? 72 yrs 0 mos. 16 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Cooper

6 DATE OF BIRTH (month, day, and year) Oct-20-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of wurk none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER James C. Baker

11 BIRTHPLACE OF FATHER (city or town) Harford Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Dashields

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs Laura B Cooper (daughter)

(Address) 2 Roland Ave

15 Filed NOV 7-1920 ROBERT B BRAUER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov - 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov - 4, 1920, to Nov - 5, 1920, that I last saw h.r alive on Nov - 4, 1920, and that death occurred, on the date stated above, at 3-45 P. m.

The CAUSE OF DEATH* was as follows:

Femoral Bronchs: Pneumonia

Uremic Coma when first seen by me.

(duration) yrs. 2 mos. da.

CONTRIBUTORY (Secondary) Chronic Bright's disease

(duration) 10+ yrs. mos. da.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Diagnosis

(Signed) M. Dobson Forbes, M. D.

11/6, 1920 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gmo Mount Cemetery	Nov 8 1920
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

HOW IS very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D4785 7 HEALTH DEPARTMENT—CITY OF BALTIMORE D4785 7

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2902 St. Paul ST.: 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie Haskell Johnson

(a) RESIDENCE. No. 2902 St. Paul ST., 12 WARD. (Resident)
(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? 59 yrs. 6 mos. 2 ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary T. Johnson

6 DATE OF BIRTH (month, day, and year) May 4. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	6	2	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Manager for

(b) General nature of industry, business, or establishment in which employed (or employer) Atlantic Trasport

(c) Name of employer Company

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles R. Johnson

11 BIRTHPLACE OF FATHER (city or town) Norfolk (State or country) Virginia

12 MAIDEN NAME OF MOTHER Charlotte M. Frazier

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs Mary T. Johnson (wife)
(Address) 2902 St Paul St.

15 Filed NOV 7 - 1920 19.... ROBERT B. KRAETER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1920, to Nov 6, 1920, that I last saw him alive on Nov 6, 1920, and that death occurred, on the date stated above, at 8 a.m. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart weakness Mitral insuf (duration) — yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chemical analysis

(Signed) Wilbur P Morgan M. D.

. 19 (Address) 315 N Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Nov 8 1920

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPA-

L 647858 HEALTH DEPARTMENT--CITY OF BALTIMORE 1920 L 647858

CERTIFICATE OF DEATH

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 160 E Eutaw Place St. 14 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Annie Poppelein

(Residence in Baltimore: No. 160 E Eutaw Place St. 68 yrs. 3 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F | 4 COLOR OR RACE: White | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Nov (Month) 4 (Day), 1852 (Year)

7 AGE: 68 yrs. 3 mos. 2 ds. | If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Nicholas Poppelein

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Susanah Thomas

13 BIRTHPLACE OF MOTHER (State or country): Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Laura V. Rickets

(Address) 160 E Eutaw Place

15 NOV 7 - 1920 ROBERT J. BRAUTER REGISTRAR

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov (Month) 6 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct, 1920, to Nov 6 1920 that I saw h[er] alive on Nov 6, 1920, and that death occurred, on the date stated above, at 2.55 P m. The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) yrs. mos. 11 ds

Contributory (SECONDARY) Chronic Interst. Nephritis (Duration) 10 yrs. mos. ds.

(Signed) Wm Caspari M. D.

Nov 6, 1920 (Address) 1163 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death	~	~	~	In the State	~	~	~
Where was disease contracted, if not at place of death?	~	~	~		~	~	~
Former or usual residence	~	~	~		~	~	~

19 PLACE OF BURIAL OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: Nov 9/ 1920

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should

Spvc.—6-9-19—H. P. Co.—1000 Bks.

D47859

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47859

X 118

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara J. Robinson

(a) RESIDENCE. NO. Mercy Hospital ST., WARD. York Pa.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 17 ds. How long in U. S., if of foreign birth? 48 yrs. 8 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. A. Robinson

6 DATE OF BIRTH (month, day, and year) Feby-19-1872

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) York Penna.

PARENTS

10 NAME OF FATHER Antonie Geuer

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known not known

12 MAIDEN NAME OF MOTHER Teresia Glassmyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Penna

14 Informant Records Mercy Hospital (Address) Baltimore.

15 Filed NOV 7 - 1920 ROBERT B. LAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/6/20, 19

17 I HEREBY CERTIFY, That I attended deceased from 10/20/, 19 21, to 11/6/20, 19, that I last saw h[illegible] alive on 11/6/20, 19, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows: Abdominal Abscess

(duration) yrs. 4 mos. da.

CONTRIBUTORY (Secondary) Uterine Fibroma.

(duration) yrs. X mos. 3 6 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 10/27/21

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) J. D. Ridgely, M. D

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
York Penna	Nov 7/ 192

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPA- ... may be properly classified.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No definite history of cause of abdominal abscess. Uremic poisoning acute autointoxication

Spec.—6-9-19—H. P. Co.—1000 Bks.

144182
D47860

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47860

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Freda Frees.

(a) RESIDENCE. NO. 02 N. Paca St. Baltimore WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 29. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Fritz Frees

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Ritzman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant

(Address)

15 Filed NOV 7 - 1920 ROBERT F. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1920, to Nov 6, 1920, that I last saw h Er alive on Nov 6, 1920, and that death occurred, on the date stated above, at 9.45 A. m.

The CAUSE OF DEATH* was as follows: Diarrhoea not dysentry

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. D. Durán, M. D.

, 19 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cems	11/8 1920
20 UNDERTAKER	ADDRESS
D. F. McCully	130 E. Fort

Print in very important. See instructions on back of certificates. FOR STATISTICS OF OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

Laura Garner.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1047861 92 1047861

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 George ST. 17 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Garner

(Residence in Baltimore: No. 605 George. St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem. | 4-COLOR OR RACE, Col. | 5-~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED,~~ (Write the word.) Widow

6-DATE OF BIRTH, ... August ....., 1870
(Month) (Day) (Year)

7-AGE, 50 yrs. — mos. — ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Mr Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Jennie Pitcher

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Garner

(Address) 605 George St

15- NOV 7 - 1920 Filed....., 191..... ROBERT L. KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 2, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 31 1920, to Nov 2 1920, that I saw h[er] alive on Nov. 2 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Mark C. Wayne M. D.

Nov 7, 1920 (Address) 1906 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn | DATE OF BURIAL, Nov 7, 191

20-UNDERTAKER, Edwin Hess Co | ADDRESS 518 N Bond St

L47862 HEALTH DEPARTMENT---CITY OF BALTIMORE L47862

CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO. C 14[illegible]

CITY OF BALTIMORE: (No. 400 Spaulding Ave. St. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret M. Conry.

(Residence in Baltimore: No. 238 S. Collington Ave. St.; 29 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female. | 4-COLOR OR RACE: White | 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: April (Month) 2nd (Day), 1881 (Year)

7-AGE: 39 yrs. 7 mos. 6 ds. If LESS than 1 day, hrs., or min.? 886

8-OCCUPATION
(a) Trade, profession or particular kind of work: Buyer for Hub Co.
(b) General nature of industry, business, or establishment in which employed (or employer): Charles & Balto Sts.

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Patrick Conry

11-BIRTHPLACE OF FATHER (State or country): Ireland.

12-MAIDEN NAME OF MOTHER: Julia A. McDonough

13-BIRTHPLACE OF MOTHER (State or country): Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Julia Conry (mother)

(Address) 2443 Eastern Ave

NOV 7 - 1920 Filed, 191 ROBERT B. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: November (Month) 4 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1920, to, Nov. 4 1920, that I saw h[illegible] alive on Nov. 3 1920, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Acute Mastoiditis, Right

(Duration) yrs. mos. 26 ds.

Contributory (SECONDARY): Abscess of Brain

(Duration) yrs. mos. 2 ds.

(Signed) W. Raymond McKenzie M. D.

Nov. 6, 1920 [Address] 11 E. Chase St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Patricks Cemetery | DATE OF BURIAL: Nov 8 1920

20-UNDERTAKER: John A. T. Moran | ADDRESS: 3008 E. Fayette St.

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047863 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047863

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 534 W. Lanvale ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Redgley

(a) RESIDENCE. NO. 534 W Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not stated

6 DATE OF BIRTH (month, day, and year) Dec. 2-1862

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
59	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook D21

(b) General nature of industry, business, or establishment in which employed (or employer): Unemployed

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: James Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Lydia Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. Florence Brown (Cousin)
(Address) 534 W. Lanvale St.

15 Filed NOV 7 - 1920 ROBERT P. LEA
Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1920

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1920, to Nov 5, 1920
that I last saw her alive on Nov 5, 1920
and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Edw. V. Shyer M. D.

11/6, 1920 Address) 1118 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Nov. 8th 1920
20 UNDERTAKER: Jno. M. Johnson	ADDRESS 1234 Eutaw St.

THIS is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1047864 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047864

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Tibbore

(Residence in Baltimore: No. Unknown St.; ....yrs.,....mos.....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. March- 29, 1861.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
59 yrs. 7 mos. 7 da.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General natnre of industry, business, or establishment in which employed (or employer): 006

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Patrick J. Brady, Act. Warden

(Address) Md. Penitentiary for Exec.

NOV 7 - 1920 ROBERT B KRAUTER

Filed....., 191.... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November- 6, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March- 27 1914, to November- 6 1920, that I saw him alive on November- 6 1920, and that death occurred, on the date stated above, at 7 30 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure - Exhaustion - Cachexia
Cirrhosis of Liver - Chronic Interstitial Nephritis - Myocarditis + Enteritis (alcoholic, Syphilitic?)
(Duration) yrs. 2 mos. 5 da.

CONTRIBUTORY (Secondary) General Passive congestion
Dyscrasia (Duration) 6 yrs. 7 mos. 9 da.

(Signed) William F. Schwark M. D.

Nov- 7..., 1920 (Address) Md. Penitentiary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 6 yrs. 7 mos. 9 da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence Baltimore, Md.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
E. Mayo Hampden	Nov. 8., 1920

20-UNDERTAKER Horace P. Burgee & Son ADDRESS 363 Hall. St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047865 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047865

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1520 Covington ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine M. Kelly

(a) RESIDENCE. No. 1520 Covington ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm J. Kelly

6 DATE OF BIRTH (month, day, and year) May 14 - 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ood

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Fredk. Kuhlond

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Eliz Morris

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mary Ellick
(Address) Washington Road.

15 NOV 7 - 1920 ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-5- 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3rd, 1920, to Nov 5-, 1920, that I last saw her alive on Nov 5-2, 1920, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Arthritis (multiple) Chr. and Hypertrophic.

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myo-cardelus + Valvular Insufficiency (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) T. A. Shepard, M. D.

11/6, 1920 (Address) 423 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Nov 7 1920
20 UNDERTAKER	ADDRESS
F A Krause & Son	703 Hanover

TION is very important. See instructions on back of certificates. be properly classified. Exact statement of OCCUPA

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47866

HEALTH DEPARTMENT—CITY OF BALTIMORE

104

D47866

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. 539 W. Cross ST. 21 WARD)

2-FULL NAME Joseph Bowman

(a) RESIDENCE. No. 539 W. Cross ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None — 100

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Bowman

11 BIRTHPLACE OF FATHER (city or town) Ga.
(State or country)

12 MAIDEN NAME OF MOTHER Annie Mosley

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Joseph Bowman
(Address) 539 W. Cross St

15 NOV 8-1920 ROBERT I. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/5/20

17 I HEREBY CERTIFY, That I attended deceased from 10/28/20 to 11/5/20
that I last saw him alive on 11/5/20
and that death occurred, on the date stated above, at 9.00 P m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Gastro-Enteritis

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Bunyon Bowley, M. D.

11/6/20 19 (Address) 908 S. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Nov 8 1920
20 UNDERTAKER	ADDRESS
L. L. Brown & Son	108 W Monto

TION is very important. See instructions on back of certificates. If may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047867

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047867

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 S. Durham ST.: V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Downing

(a) RESIDENCE. No. 28 S. Durham ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 14 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 700

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John F. Downing

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Vernella Rennie

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mr. John F. Downing
(Address) 28 S. Durham

15 NOV 8 - 1920 ROBERT B. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1920

17 I HEREBY CERTIFY, That I attended deceased from 7 30 p m. Nov. 6, 1920, to 2 a m Nov. 7, 1920, that I last saw h.... alive on Nov. 7th, 1920, and that death occurred, on the date stated above, at 2 20 a m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

.....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Collenberg M. D.

Nov. 7 1920 (Address) 1840 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov. 8 1920

20 UNDERTAKER Jos. J. Kerr ADDRESS 156 N. Luzerne

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Willey

D47868 HEALTH DEPARTMENT—CITY OF BALTIMORE D47868

CERTIFICATE OF DEATH. X78

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mollie Willey

(a) RESIDENCE. No. Irvington ST. Va WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late James Willey

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	abt 59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Irvington Va.

PARENTS

10 NAME OF FATHER B. J. Hayden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Mrs. Thomas K. Burke 417 N. Milton Ave

15 NOV 8 - 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7 1920

17 I HEREBY CERTIFY, That I attended deceased from 11/5/ 1920 to 11/7 1920, that I last saw h[illegible] alive on 11/7/ 1920, and that death occurred, on the date stated above, at 7 15 a m.

The CAUSE OF DEATH* was as follows:

Chronic Arterial Hypertension

Acute Myocardial Infarction

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goldsborough, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Irvington Cemetery Va	Nov 9 1920
20 UNDERTAKER	ADDRESS
W. M. Cook	502 E Northern

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047869

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1047869

1-PLACE OF DEATH

REGISTERED NO. 104

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Gardner

(a) RESIDENCE. No. 303 S. Durham St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7-1920

7 AGE: Years 7 Months Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Kulick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Mary Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record
(Address) J 666

15 NOV 8=1920 ROBERT B. LEAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6th 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 5th, 1920, to Nov 6th, 1920, that I last saw her alive on Nov 6th, 1920, and that death occurred, on the date stated above, at 7 00 a.m.

The CAUSE OF DEATH* was as follows:

Diarrhoea 1st dysentery

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Baron M. D.

11/6, 1920 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: Nov 8 1920

20 UNDERTAKER: Wm Hawkins

ADDRESS: 1668 Eastern

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- ...n may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

647870 HEALTH DEPARTMENT—CITY OF BALTIMORE 647870

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 S. Harris Al ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willian Earnest Brandt

(a) RESIDENCE. No. 906 S. Harris alley 1st WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 22 '20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
—	—	—	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none ppd

(b) General nature of industry, business, or establishment in which employed (or employer) infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER August Brandt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md.

14 Informant Wm Brandt (Grandfather)
(Address) 906 S. Harris alley.

15 Filed ... 19 NOV 8-1920 ROBERT E LEAUTZ
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1920, to Nov 7, 1920, that I last saw him alive on Nov 7, 1920, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion - Starvation

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Mal nutrition - gastro enteritis.

(Twin) (duration) ... yrs. ... mos. 16 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A. M. Wenger M. D.

(Address) 3048 Bonnell Ct. Nov 7. 1920

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
I-st German	Nov 8 1920
20 UNDERTAKER	ADDRESS
Peter Nicolaus	2046 Eastern Av

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

WEAVER

1047871

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047871

CERTIFICATE OF DEATH.

4120

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 705 W. Redwood ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Weaver

(Residence in Baltimore: No. 705 W. German St.; 45 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Feb 20, 1867.
(Month) (Day) (Year)

7-AGE, 53 yrs. 1 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Rod Worker 066
(b) General nature of industry, business, or establishment in which employed (or employer): Basket Manufacturer

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Peter Weaver

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Catherine Reynolds

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred Dickroon

(Address) 211 E Lafayette St

15- Filed NOV 8 - 1920, 191.... ROBERT B. FRAUTEN, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 5, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 3 1920, to Nov 5 1920, that I saw h.....alive on Nov 4 1920, and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows:

Ill-defined Intestinal Obstruction

(Duration) ... yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(Duration) ... yrs. — mos. 10 ds.

(Signed) Edward Talbot M. D.

Nov 7, 1920. (Address) 1339 N. Monroe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Bal Co	Nov 8, 191..
20-UNDERTAKER	**ADDRESS**
Geo Lewis & Son	Baltimore

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D47872 (1) — X53 D47872

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Long.

(a) RESIDENCE. NO. Blacksburg Va ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white.	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 11-1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Samuel Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sue Bryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) J. H. Woods

15 Filed , 19 ROBERT B KRAUTER Registrar

NOV 8-1920 Burial Permit 01

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 — 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 20, 1920, to Nov 6, 1920, that I last saw h[illegible] alive on Nov 6, 1920, and that death occurred, on the date stated above, at 4.33 p m.

The CAUSE OF DEATH* was as follows:

Acute Leukaemia (Myeloid?)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) V. R. Mason, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Whitethorne Va	Nov 8 1920
20 UNDERTAKER	ADDRESS
1201 2 Fayette St	John O Mitchell

TION is very important. See instructions on back of certificates.

Tinkler

D47873 HEALTH DEPARTMENT—CITY OF BALTIMORE D47873

CERTIFICATE OF DEATH.

71

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1214 Druid Hill Ave ST.; 13 WARD) REGISTERED No. C

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Tinkler

(Residence in Baltimore: No. 1214 Druid Hill Ave St.; yrs., mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M.

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH: Oct. 29, 1920
(Month) (Day) (Year)

7-AGE: ..... yrs. 9 mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): 1214 Druid Hill Ave

PARENTS.

10-NAME OF FATHER: Walter Tinkler

11-BIRTHPLACE OF FATHER (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Sarah Forside

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Tinkler

(Address) 1214 Druid Hill Ave

15- NOV 8 - 1920 ROBERT E KRAUTER
Filed ....., 191.... Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Nov. 6, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Convulsions

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Thomson M. D.
(Coroner.)

..... 192.. (Address) 363 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Dist Park Balto Co

DATE OF BURIAL: Nov. 8 19..

20-UNDERTAKER: Chenowith Son

ADDRESS: Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47874

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47874

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2618 Hampden Ave ST.) (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorraine Carr

(a) RESIDENCE. NO. 2618 Hampden Ave WARD.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 3 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Arthur Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Nannie Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant A M Carr

(Address) 2618 Hampden

15 NOV 8 - 1920 ROBERT B KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1920, to Nov. 6, 1920, that I last saw her alive on Nov. 6, 1920, and that death occurred, on the date stated above, at 2 1/2 P m.

The CAUSE OF DEATH* was as follows:

Non Congenital Atalectasis

Prematurity 6 mos.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Machin, M. D.

, 19 (Address) 4119 Falls Rds.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Nov 8 1920

20 UNDERTAKER Chenowith & Son ADDRESS Chestnut & Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047875 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047875

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4009 Woodbine Ave ST.: 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry L. Wiesner

(a) RESIDENCE. No. 4009 Woodbine Av ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) March 21 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher of Languages

(b) General nature of industry, business, or establishment in which employed (or employer) 168

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Eberhardt Wiesner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lessner Riginia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. E. Cragg

(Address) 4009 Woodbine ave

15 NOV 8 - 1920

ROBERT J. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1920

17

I HEREBY CERTIFY, That I attended deceased from Apr. 20, 1920, to Nov 5, 1920, that I last saw h[illegible] alive on Nov 5, 1920 and that death occurred, on the date stated above, at 11. A m.

The CAUSE OF DEATH* was as follows:

Hypernephroma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Nathaniel Barth, M. D.

, 19 (Address) 2731 Parkwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 8 19
20 UNDERTAKER	ADDRESS
Josiah Sykes	1600 N North Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1947876 HEALTH DEPARTMENT—CITY OF BALTIMORE 1947876

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 106 N Fremont St ST.: 4 WARD) 168

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Orson N. Garlinger

(Residence in Baltimore: No. 106 N Fremont St— St. 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... November ..... 1 ..... (Month) (Day) (Year)

7-AGE, ... 60 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Painter
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, B. A. Garlinger

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Black

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... H. R. Pierce .....

(Address) 1210 Shepard St N.W Washington DC

15- NOV 8 - 1920 191.... ROBERT I. LRAUTER Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov ..... 5 ....., 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Inhalation of Illuminating Gas

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accident

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... W K Gorman ..... M. D. (Coroner)

11-8 ....., 1920 (Address) 117 N Paca St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hagerstown Md

DATE OF BURIAL, Nov 8., 1920

20-UNDERTAKER Chas. G. Black

ADDRESS 7th & Northern Ave

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very important. PHYSICIANS should state in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47877

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-47877

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1 Washington Road ST. 75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond E. Weeks

(a) RESIDENCE. NO. 1 Washington Road ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 17th 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter Rest. Ofcr.

(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Odenton Md

PARENTS

10 NAME OF FATHER Sanford B. Weeks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prov. Jersey

12 MAIDEN NAME OF MOTHER Estella Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sanford B Weeks
(Address) 1 Washington Road

15 Filed NOV 8 - 1920 . 19 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6th 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 2nd, 1920, to Nov. 6th, 1920, that I last saw h.. alive on Nov 6th, 1920, and that death occurred, on the date stated above, at 1-30 p.m.

The CAUSE OF DEATH* was as follows:

Anaemia

OVW

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Pneumonia Bilateral

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Asphyxia (Febrile)

(Signed) Lemuel Fox, M. D.

(Address) 740 Dolphin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Odenton Md	11-9 1920
20 UNDERTAKER	ADDRESS
Grahame I. Walker	1300 [illegible]

THIS is very important. See instructions on back of certificates. It may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47878

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47878

CERTIFICATE OF DEATH.

1920

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 144 East St. ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blondel Gaskins

(a) RESIDENCE. NO. 144 East ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Walter Gaskins

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer) general

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Elias Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alexandria Va

12 MAIDEN NAME OF MOTHER Hattie Hunter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Emma Brown
(Address) 144 East St

15 NOV 8 - 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1920, to Nov. 4, 1920, that I last saw h[illegible] alive on Nov. 3, 1920, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jas B Robinson, M. D.

11/5, 1920 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	Nov 8 1920
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47879

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47879

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH Robt Garrett Hosp

CITY OF BALTIMORE: (No. 27 N Carey ST. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Eckman

(a) RESIDENCE. No. 2009 N. Saratoga ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug -1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER Harry R. Eckman

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Amelia J Nickerson

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Harry R. Eckman (Address) 2009 N. Saratoga St.

8-1920 Filed , 19 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1920, to Nov 7, 1920, that I last saw him alive on Nov 7, 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Decomposition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical Exam

(Signed) J. W. B. Clift, M. D.

Nov 7, 1920 (Address) 27 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Nov 9 1920
20 UNDERTAKER Robert Brooks & Son	ADDRESS 17 S Calhoun St

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47880 HEALTH DEPARTMENT—CITY OF BALTIMORE D 47880

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2503 Dulaney St ST.: 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Charles alexander Adams

(a) RESIDENCE. No. 2503 Dulaney St ST., 20 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 20-1920

7 AGE Years Months Days: 18

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Charles Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Nettie Seeger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: George Seeger

(Address) 2503 Dulaney St

Filed NOV 8 — 1920

ROBERT B. BEAUTER Registrar

Burial Permit Oleet

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1920, to Nov 7, 1920

that I last saw h. alive on Nov. 7, 1920

and that death occurred, on the date stated above, at 10 p.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. S. Woodruff M. D.

. 19 (Address) Franklin Square Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ridge Cemetery — DATE OF BURIAL: Nov 8 19-0

20 UNDERTAKER: George Schnatterer — ADDRESS: 2111 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047881

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 047881

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Anna V. Briddell ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME " " "

(a) RESIDENCE. No. 1004 E Hoffman ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Joshua Briddell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Gibbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Lindsey Briddell
(Address): Halbrook Mass

15 NOV 8 - 1920 ROBERT F. KRAUTER Registrar

Burial Permit 01678

Dr Magness E Preston st

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1920, to Nov. 7, 1920, that I last saw her alive on Nov. 6, 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage (Apoplexia)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. Lee Magness, M. D.

Nov 7 1920 (Address) 1206 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cem	Nov 7/ 1920
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Nath

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047882 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047882

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital REGISTERED NO. 1727

CITY OF BALTIMORE: (No. Calvert St. St. 14 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Fitzgerald

(a) RESIDENCE. No 1533 Park Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daughter of Thomas Fitzgerald

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Thomas Fitzgerald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Maria Mayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mrs Wm A. Gale

(Address) 1523 Park ave

NOV 8 - 1920

ROBERT I. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1920

17 I HEREBY CERTIFY, That I attended deceased from October 10, 1920, to Nov. 6, 1920, that I last saw h alive on Nov 6, 1920, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows: Streptococcic Septicaemia

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Enterocolitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Culture

(Signed) Edw. L. Kaufman, M. D.

. 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	11-9-1920

20 UNDERTAKER Henry W. Jenkins Sons Co ADDRESS Orchard & McCulloh

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047883 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047883

CERTIFICATE OF DEATH. X 42

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hosp. (St.) 14 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Jones

(a) RESIDENCE. No. 1630 Division St., Ward. Virginia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Married

5a If married, widowed, or divorced (or) WIFE of Howard Jones

6 DATE OF BIRTH (month, day, and year) Mar 14, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 097

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Silas Astin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lizzie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Howard M. Young

(Address) 1630 Division St.

NOV 8 - 1920

ROBERT J. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7 1920

17

I HEREBY CERTIFY, That I attended deceased from 10/15, 1920, to 11/7, 1920, that I last saw h alive on 11/7, 1920, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ovary.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) General Carcinoma

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Yes Date of 10, 27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lewis A. Rodgers M. D.

11/8 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sales White Co Cemetery	Nov 8 '20

20 UNDERTAKER	ADDRESS
George H. Holland	1691 Druid Hill Ave

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Avon R. Thomas

1047884 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047884

CERTIFICATE OF DEATH.

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 1021 N. Calhoun St. 16 150 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Avon Rufus Thomas

(Residence in Baltimore: No. 1021 N. Calhoun St. St.; yrs. 1 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Single

6-DATE OF BIRTH: October 1, 1920 (Month) (Day) (Year)

7-AGE: yrs. 1 mos. 7 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Albert Thomas

11-BIRTHPLACE OF FATHER (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: Roberta Mosley

13-BIRTHPLACE OF MOTHER (State or Country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. Thomas

(Address) 1021 N. Calhoun St.

15- Filed NOV 8 - 1920, 191.. ROBERT F. KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 7, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest~~ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~inquest~~ (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) ~~no history~~

(Duration) yrs. mos. ds.

(Signed) J. S. Hemmeter M. D. (Coroner.)

Nov. 7, 1920 (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: Loudon Park — DATE OF BURIAL: Nov 8, 1920

20-UNDERTAKER: Wm. H. Eline Sons — ADDRESS: 1400 Mosher

important. See instructions on back of certificate. ...may be properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047885 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047885

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1406 Orleans ST.; 5 (WARD) 8

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Watson Fulton Jr

(a) RESIDENCE. No. 1406 Orleans ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5 1920

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Not any 000

(b) General nature of industry, business, or establishment in which employed (or employer): Not any

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Watson Fulton

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. C.

12 MAIDEN NAME OF MOTHER: Mary Fulton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

14 Informant: Watson Fulton Sr

(Address) 1406 Orleans

NOV 8 - 1920 ROBERT T. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1920

17

I HEREBY CERTIFY, That I attended deceased from On Nov 7, 1920, to ... 19..., that I last saw him alive on Nov 7, 1920, and that death occurred, on the date stated above, at 5.50 a.m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D.

11-8, 1920 (Address) 822 W. Pond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Auburn Cem.	Nov. 8th 1920

20 UNDERTAKER: Harry A Vodery ADDRESS: 1725 Orleans St

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Baltimore, Md. Nov. 26, 19

I do hereby make oath that the name and sex of child given on Baltimore City Health Department Death Certificate No. D-47885, as Watson Fulton Jr., and the sex as male, is incorrect; that same should be recorded as Alvinia Fulton and the sex given as female.

J. E. Thomas

Physic

Subscribed and sworn to before me this 26th day of November, 1

Cecil Luther

Notary Publ

Spec.—8-24-14—M. & T.—2000 Bks.

D47886

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47886

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1513 Prestman St

CITY OF BALTIMORE: (No. 1307 N. Mount St. ST.; 15 WARD) 37

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond Price

(Residence in Baltimore: No. 1307 N. Mount St.; Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.) Single

6-DATE OF BIRTH, May (Month) 11 (Day), 1920 (Year)

7-AGE, yrs. 5 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): ppp

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Richard Benyaun

11-BIRTHPLACE OF FATHER (State or Country), St Mary's Co. Md

12-MAIDEN NAME OF MOTHER Annie Price

13-BIRTHPLACE OF MOTHER (State or Country), Annapolis, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Price (mother)

(Address) 1307 N. Mount St.

15- NOV 8 - 1920, 191.... ROBERT J. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 4 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 27 1920, to Nov. 4 1920, that I saw h[im] alive on Nov 4 1920, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Hereditary Syphilis

Life (Duration) ...yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs.....mos.....ds.

(Signed) Alma S. Rotthoff M. D.

Nov. 4, 1920 (Address) 210 E Bolton Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. 2 mos. 7 ds. In the State Life yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1307 N. Mount St.

19-PLACE OF BURIAL OR REMOVAL, St Peters

DATE OF BURIAL, Nov. 7., 1920.

20-UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

Spec.—8-24-14—M. & T.—2000 Bks.

D47887 HEALTH DEPARTMENT—CITY OF BALTIMORE D47887

CERTIFICATE OF DEATH.

REGISTERED No. C 13 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 Rectory Lane ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chester Black Jr.

(Residence in Baltimore: No. 519 Rectory Lane St.; ..... yrs. Life mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Single

6-DATE OF BIRTH, October 26, 1920 (Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), 519 Rectory Lane

PARENTS.

10-NAME OF FATHER, Chester D. Black.

11-BIRTHPLACE OF FATHER (State or Country), Jonestown Miss.

12-MAIDEN NAME OF MOTHER Georgeanna Hann.

13-BIRTHPLACE OF MOTHER (State or Country), Bacto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chester D. Black.

(Address) 519 Rectory Lane.

15- Filed NOV 8 - 1920, 191.... ROBERT J. [illegible] Clerk. Burial Permit Record.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 5, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 26 1920, to Nov 5 1920, that I saw him alive on Nov 4 1920, and that death occurred, on the date stated above, at 5-30 A.M.

The CAUSE OF DEATH* was as follows:

Transition with Hepatitis

Acute accompanied with

Jaundice (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Premature Birth (7th month) (Duration) ..... yrs. Life mos. ..... ds.

(Signed) C. F. Shelley M. D.

Nov 8, 1920 (Address) 3.844 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Marys Hanover Pa. DATE OF BURIAL, Nov 10, 1920

20-UNDERTAKER Ehrenwerth Son ADDRESS Chestnut Ave

Spec.—8-24-14—M. & T.—2000 Blks.

L047888

HEALTH DEPARTMENT—CITY OF BALTIMORE

L047888

CERTIFICATE OF DEATH.

39

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3038 Boston St. ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Mary Czepulianis

(Residence in Baltimore: No. 3038 Boston St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Oct (Month) 2 (Day), 1900 (Year)

7-AGE. 20 yrs. 1 mos. 4 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At home
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE. (State or Country) Balto. Md

PARENTS.

10-NAME OF FATHER. Frank Zubrowska

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER. Katherine Pichocka

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs F. Zubrowska

(Address) 3038 Boston St

15- Filed NOV 8-1920, 191. ROBERT P. KRAUTH Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov (Month) 6 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1920, to Nov 6 1920, that I saw her alive on Nov 5 1920, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma of superior maxilla

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Eugene Zeller M. D.

Nov. 6, 1920 (Address) 1818 Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St Stanislaus DATE OF BURIAL. Nov 9, 1920

20-UNDERTAKER John M Weber ADDRESS 1803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 47889 (1448) — D 47889 — 93

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Neuman

(a) RESIDENCE. No. 808 S. Curley St ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ehild.

6 DATE OF BIRTH (month, day, and year): Sept. 16th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, bosiness, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS
10 NAME OF FATHER: George E. Neuman
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.
12 MAIDEN NAME OF MOTHER: Jennie Amant
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Hospital Record
(Address): J H H

15 NOV 8 - 1920
ROBERT B [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 6th 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 28th, 1920, to Nov 6th, 1920, that I last saw her alive on Nov 6th, 1920, and that death occurred, on the date stated above, at 6 45 a. m.

The CAUSE OF DEATH* was as follows:
Emphysema (Staphylococcus)
, over
(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W Barton, M. D.
, 19 (Address) J H H Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Third Evangelical Lutheran	Nov. 8 1920
20 UNDERTAKER	ADDRESS
Lilly & Zeller	400 S. Wolfe

HOW IS very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Plain abscess - operation for drain.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47890 D47890

CERTIFICATE OF DEATH.

REGISTERED NO. 437

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital. ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Holland

(a) RESIDENCE. No. 753 Mulberry St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Simon Dixon

11 BIRTHPLACE OF FATHER (city or town) Baltimore,
(State or country) Md.

12 MAIDEN NAME OF MOTHER Georgianna Howard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Md.

14 Informant Hospital Records.
(Address) New City Hospital.

15 Filed NOV 8 - 1920 ROBERT E KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 6, 1920

17 I HEREBY CERTIFY, That I attended deceased from October 21, 1920, to November 6, 1920, that I last saw her alive on November 5, 1920, and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Lung abscess (non-tuberculous.)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Syphilis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) R H Herman, M. D.

11/6/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	Nov 10 1920
20 UNDERTAKER Daniel Eardi	ADDRESS 916 Eastern ave

Note.—It is very important. See instructions on back of certificates. Exact statement of OCCUPA-

D47891 HEALTH DEPARTMENT—CITY OF BALTIMORE D47891

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 79

CITY OF BALTIMORE (No. City Jail ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Romano

(Residence in Baltimore: No. 913 Middle St St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col.	Married

6-DATE OF BIRTH, ... (Month) (Day) 1883 (Year)

7-AGE,	If LESS than 1 day,
37 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... David Easton

(Address)..... 916 Pennsylvania ave

15- NOV 8 1920 191.... ROBERT E BEAUTER Burial Permit (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan (Month) 6 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D. (Coroner.)

Jan 6, 1920 (Address) 1627 Bank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 10 da yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Jan 9 19....

20-UNDERTAKER David Easton — ADDRESS 916 Penn ave

important. See instructions on back of certificate.

D 47892

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

15 D 47892

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 1025 Cathedral St. 4th WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sarah Thompson.

(Residence in Baltimore: No. 1025 Cathedral St.; 66 yrs. 7 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Mar. 14 (Month) (Day), 1854 (Year)

7 AGE: 66 yrs. 7 mos. 23 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Cook 071
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Balt'r Md.

PARENTS

10 NAME OF FATHER: Don't know

11 BIRTHPLACE OF FATHER (State or country): Don't know

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (State or country): Don't know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. N. Strother

(Address) 1025 Cathedral

NOV 8 - 1920

Filed ....., 191 ..... ROBERT P. LAMDIN Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov (Month) 7th (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4th, 1920, to Nov 5th 1920 that I saw her alive on Nov 6th, 1920 and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Has been in feeble health for several years. I have seen her from time to time, and her health & strength have gradually declined. She eventually

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) died from the infirmities of age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lud. S. Loy. M. D.

....., 191... (Address) 1028 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Rock Hall Md. — DATE OF BURIAL: Nov 9, 1920

20 UNDERTAKER: Daniel Earle — ADDRESS 916 Pennsylvania

ONE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 47893

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47893

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Sq Hospital 16 182

CITY OF BALTIMORE (No. ..... ST.; WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Magdalena Dorsch

(Residence in Baltimore: No. 643 N Walbrook St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

Single

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	W	

6-DATE OF BIRTH, August 12 / 1897
(Month) (Day) (Year)

7-AGE 23 yrs. 2 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country) Richelieu Howard Co Md

PARENTS.

10-NAME OF FATHER, Henry Dorsch

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Madelena Dittel

13-BIRTHPLACE OF MOTHER (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Magdalena Dorsch

(Address) 119 W.C Paul Street

15-

Filed NOV 8 1923 Burial Permit Issued

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 6, 1917
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH was as follows:

Gun Shot Wounds Homicide

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Krabe M. D.
(Coroner)

11 6 17 (Address) 1376 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cem	Nov 9, 1923

20-UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W. Balto St

important. See instructions on back of certificate.

D.47894

Spec.—6-9-19—H. P. Co.—1009 Bks.

D.47894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 Mc. McHenry ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie P. Hall

(a) RESIDENCE. No 531 Mc. McHenry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F-1	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dead

6 DATE OF BIRTH (month, day, and year) ? 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James Whatkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Jane Spalding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Edwina Hall
(Address) 531 McHenry

15 Filed NOV 8-1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/5/1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1920, to Nov. 5, 1920
that I last saw her alive on Nov 5, 1920
and that death occurred, on the date stated above, at 8:20 P m.
The CAUSE OF DEATH* was as follows:

Toxemia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uterine Carcinoma

(duration) yrs. 10 mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 7/10/20

Was there an autopsy? No

What test confirmed diagnosis? Pathological

(Signed) W. H. Tompkins, M. D.

(Address) 101 S Dunbar Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 8 1920
20 UNDERTAKER	ADDRESS
James H. Deems	1303 Pennsylvania Ave

Fill in very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.47895 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47895

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 24 East Lanvale ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Leo Donahue

(a) RESIDENCE. No. 24 East Lanvale ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Sept. 16, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas J. Donahue

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A. McAuliffe

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Mary A. Donahue
(Address) 24 East Lanvale Street

15 Filed 8-1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-6 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb 29th, 1920, to Nov 6th, 1920, that I last saw h.. alive on Nov 6, 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Intercurrent

(duration) 5 yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Dunk

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Joseph T. Kenny, M. D.

. 19 (Address) Walbert Apartments

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	11/9, 19 20
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

THIS is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47896 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47896

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 364 W. Biddle ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Plummer

(a) RESIDENCE. NO. 364 W Biddle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day 11 hrs. or min.
—			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None - Child
(b) General nature of industry, business, or establishment in which employed (or employer) "
(c) Name of employer "

000

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Plummer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Lawry

13 BIRTHPLACE OF MOTHER (city or town) Boydton
(State or country) Virginia

14 Informant
(Address) Robert P. Harrison.

NOV 8 - 1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1920, to Nov. 5, 1920, that I last saw her alive on Nov 5, 1920 and that death occurred, on the date stated above, at 3P m.

The CAUSE OF DEATH* was as follows:

Prematurity
(32 weeks foetus).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Foetal Syphilis -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Reese, M. D.

11-5, 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL NOV 8 - 1920 19

20 UNDERTAKER — ADDRESS

Commissioner Health.

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47897 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47897

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 Rosedale Terrace ST.; 20 37 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Hickman

(Residence in Baltimore: No. 421 Rosedale Terrace St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	single

6-DATE OF BIRTH, Oct (Month) 19 (Day), 1878 (Year)

7-AGE,	If LESS than 1 day,
42 yrs. 0 mos. 19 ds.	....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Plasterer 057
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER, George W. Hickman

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Sarah E Morgan

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Sarah E. Hickman

(Address): 421 Rosedale Terrace

15- NOV 8 - 1920 Robert P. Harrison,
Filed....., 191.....
Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 7 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 15 1920, to Nov 7 1920 that I saw h- alive on nov 7 1920, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

nov

Chronic Malaria

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Anaemia (Pernicious)

(Duration) yrs. mos. ds.

(Signed) J. H. Phillips M. D.

Nov 8, 1920 (Address) 2300 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery DATE OF BURIAL, Nov. 9, 1920

20-UNDERTAKER Geo. A. Herbig ADDRESS 2001 W Baltimore St.

Dr Phillips Bentalou + Edmonson Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 47898

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 47898

CERTIFICATE OF DEATH.

9-92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 Marshall ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James E. Washburn.

(a) RESIDENCE. No. 1708 Marshall ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 2. 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		14	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 500

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Chas Washburn.

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Dorothy Pusch.

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Dorothy Washburn
(Address) 1708 Marshall St.

15 Filed NOV 8-1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 7th 1920

17 I HEREBY CERTIFY, That I attended deceased from November 7th, 1920, to November 7th, 1920, that I last saw h[illegible] alive on November 7th, 1920, and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

Fiber Pneumonia, 1 day
Laryngeal Diphtheria
(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) General Toxemia 1 hour
(duration) — yrs. — mos. 1 hr.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No Have body examined by Coroner

What test confirmed diagnosis? Clinical findings

(Signed) Harry Kennel M. D.

(Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL Nov 9th 1920

20 UNDERTAKER William Cook.

ADDRESS 502 E. Hall

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47899 (Shafer) HEALTH DEPARTMENT—CITY OF BALTIMORE D.47899

CERTIFICATE OF DEATH. X 30

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: 7 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenneth E. Schafer

(a) RESIDENCE. No. McDonough School St., Md Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 17-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles S Shafer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elsie Fox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) J H H Balto

15 Filed NOV 8-1920 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 - 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1920, to Nov 7, 1920, that I last saw h~~is~~ alive on Nov 7, 1920, and that death occurred, on the date stated above, at 11-P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar Puncture & Smear

(Signed) W R Dawson, M. D.

, 19 (Address) J H H Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Highfield Md	Nov 9 1920

20 UNDERTAKER	ADDRESS
Wm E. Black	927 N. Broadway

TION is very important. See instructions on back of certificates. of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47900

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47900

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3361- Belair Road ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanna R. Martin

(a) RESIDENCE. No. 3361- Belair Road ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
WIFE of Benja. C. Martin.

6 DATE OF BIRTH (month, day, and year) 2/24/1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) HOU

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER George Erdman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Erdman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas. H. Martin
(Address) 3361- Belair Road

15 Filed 8-1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1920

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to Nov. 6, 1920, that I last saw her alive on Nov. 5th, 1920, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Williamson, M. D.

11/8 1920 (Address) Roseburg Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cemetery Annapolis	11/10/1920

20 UNDERTAKER ADDRESS

George J. Ruth. 1735 Hanford Ave

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47901

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47901

CERTIFICATE OF DEATH.

50

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 E. Clement St ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Hittle

(a) RESIDENCE. NO. 500 E. Clement ST., ... WARD. 2

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cunigunda Hittle

6 DATE OF BIRTH (month, day, and year) Oct 31 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster Packer. 886

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Martin Hittle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Marian Bauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Margaret Thonds (Address) 500 E. Clement St

15 FILED NOV 8 - 1920 19.. Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-7 1920

17 I HEREBY CERTIFY, That I attended deceased from July 5 1920, to Nov 7, 1920, that I last saw him alive on Nov 5 1920, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

Cardiac Debilitation

(duration) 8 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac debilitation

(duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Suspected

What test confirmed diagnosis? Symptoms

(Signed) Henry Finn, M. D.

7/11, 1920 (Address) 1-38 W Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov 10 1920

20 UNDERTAKER Margaret G. Flynn ADDRESS 1422 Eighth

THIS IS very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47902

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47902

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Joseph Griffiss

(a) RESIDENCE. No. 2213 N. Fayette St. WARD 1

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Griffiss

6 DATE OF BIRTH (month, day, and year) Sept 10th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 061

(b) General nature of Industry, business, or establishment in which employed (or employer) Office

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mrs J. H. Griffiss

(Address) 2213 N. Fayette St

15 Filed NOV 8 - 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-6 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 19, 1920, to 11-6, 1920, that I last saw h. alive on 11-6, 1920, and that death occurred, on the date stated above, at 1.50 9 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Aortic Stenosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory

(Signed) W. M. Craig, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	Nov. 9 1920
20 UNDERTAKER Margaret D. Flynn	ADDRESS 1422 Eighth St.

Note.—Very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.47903 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.47903

CERTIFICATE OF DEATH. X 45-091

1-PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret D Randolph

(a) RESIDENCE. No. 512 Fairmont Fairmont St. W. Va. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: H H Randolph

6 DATE OF BIRTH (month, day, and year): Feb 17-1864

7 AGE: 56 Years 7 Months 21 Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10 NAME OF FATHER: Wm. Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: S Carencross

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Hospital Record J. H. H. (Address)

15 Filed NOV 8-1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 8 1920

17 I HEREBY CERTIFY, That I attended deceased from June 9th 1920, to Nov 8th 1920, that I last saw her alive on Nov 8th 1920, and that death occurred, on the date stated above, at 6th P. m.

The CAUSE OF DEATH* was as follows:

Hypernephroma

(duration) yrs. 6 mos. 1 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? West Virginia

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? X Ray

(Signed) Henry K. Ames Jr. M. D.

, 19 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fairmont West Va. DATE OF BURIAL: Nov 9 1920

20 UNDERTAKER: Wm Cook ADDRESS: 502 E Balto

IMPORTANT. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D.47904

D.47904

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH University Hospital.

CITY OF BALTIMORE: (No. ..... St.: 23 Ward) REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Eckert

(a) RESIDENCE. No. 1447 W. Cross St. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37 about			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Silver Ofr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Fred. Eckert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Kate Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edgar Pumphrey

(Address) 1442 W. Cross St

15 Nov 8 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/6 1920

17

I HEREBY CERTIFY, That I attended deceased from 10/28, 1920, to 11/6, 1920, that I last saw h[e] alive on 11/6, 1920, and that death occurred, on the date stated above, at 2.50 p m.

The CAUSE OF DEATH* was as follows:

Secondary Hemorrhage — post operative following Hernia operation — 4 months.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Inguinal Hernia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of 10/28/20

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Wm. Blum M. D.

11/6, 1920 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Nov 9 1920
20 UNDERTAKER	ADDRESS
Wm Fickus & Sons	North Ave

Print name on back of certificates. Item 14 is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047905 HEALTH DEPARTMENT—CITY OF BALTIMORE 047905

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1435 W. Lombard ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Askey

(a) RESIDENCE. No. 1435 Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 7 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jordan

6 DATE OF BIRTH (month, day, and year) March 29, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendent of

(b) General nature of industry, business, or establishment in which employed (or employer) Station P Balto.

(c) Name of employer U. S. P. O.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Askey

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Elizabeth Porter

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs. Mary P. Askey
(Address) 1435 W. Lombard Street

15 Filed NOV 9 - 1920 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1920

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1920, to Nov. 6, 1920, that I last saw h... alive on Nov 6, 1920, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease; Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A Osborne, M. D.

(Address) 2360 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	11/9 1920
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

TION is very important. See instructions on back of certificates. ...ERAL STATEMENT OF OCCUPA-

1047906 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047906

CERTIFICATE OF DEATH.

X 4 175-004

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital. ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sebastian Kolbig.

(Residence in Baltimore: No. Pikesville Balto. Co. St.; 45 yrs., mos. 1 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male.	White.	Married

6-DATE OF BIRTH, Do not know. (Month), 1 (Day), ... (Year)

7-AGE, 68 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Own

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theresa Kolbig. (wife)

(Address) Pikesville, Balto. Co.

15- NOV 9 - 1920 ROBERT P. KRAUTH

Filed....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 4th. 1920, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull,
Accidentally struck by car #508 of
U. R. & E. Co. (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Nov. 4th, 1920. (Address) 10 E. Chas. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Reisterstown Rd. Nr Brightside Ave.

Former or usual residence..... November 5th. 1920

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Nov. 7, 19....
20-UNDERTAKER	ADDRESS
Hanlon Hickey & Son	1826 North

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047907

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047907

CERTIFICATE OF DEATH.

10-087

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 E 21½ St. ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harrison Scott

(a) RESIDENCE. No. 417 E 21½ St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE 38 Years — Months — Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) born in Md Md

PARENTS

10 NAME OF FATHER George Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) born in Md

12 MAIDEN NAME OF MOTHER Martinia Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) born in Md

14 Informant Mattie May Scott
(Address) 417 E 21½ St

15 NOV 9 - 1920 ROBERT I. KRAUSER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/6/1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 2nd, 1920, to Nov 6th, 1920, that I last saw h[illegible] alive on Nov 6th, 1920, and that death occurred, on the date stated above, at 2.15 A m.

The CAUSE OF DEATH* was as follows:

Asphyxiation and acute Intoxication with Edema of Glottis

Tin (duration) x yrs. x mos. 5 ds.

CONTRIBUTORY (Secondary) acute Colitis Emaciation

Phlegmon (duration) x yrs. x mos. 2 ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas L Hall M. D.

(Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Rest Cemetery	November 1920
20 UNDERTAKER Towson and Mrs Robert A Elliott	ADDRESS 1725 Ashland Av

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

047908

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 047908

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 E. Fayette St. ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Davis

(a) RESIDENCE. NO. 2013 E. Fayette St. ST., 6 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 21-1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Agnes Nicholson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Samuel Davis (Address) 2013 E. Fayette St.

15 Filed NOV 9 - 1920 ROBERT F. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1920, to Nov 8, 1920.

that I last saw her alive on Nov 8, 1920.

and that death occurred, on the date stated above, at 12.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (duration) ... yrs. ... mos. 21 ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy (duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) William J. Power M. D.

Nov. 8 1920 (Address) 801 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Nov. 10 1920
20 UNDERTAKER Lilly and Zirkin.	ADDRESS 403 S. Wolfe St.

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1047909

HEALTH DEPARTMENT—CITY OF BALTIMORE

54 1047909

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzid Nienor

(a) RESIDENCE. No. Unknown ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed NOV 9 - 1920 ROBERT A KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 7, 1920

17 I HEREBY CERTIFY, That I attended deceased from October 28, 1920, to November 7, 1920, that I last saw her alive on November 6, 1920, and that death occurred, on the date stated above, at 12:30 A.m.

The CAUSE OF DEATH* was as follows:

Pernicious anemia.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood examination

(Signed) V Bolterman. M. D.

11/8/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Louis R. C. Reformed	Nov. 10 1920
20 UNDERTAKER	ADDRESS
Tilg & Julian	403 E. Fayette

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047910 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047910

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 137 S. Fifth St. St. 26 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Muller

(a) RESIDENCE. No. 137 S. Fifth St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Muller.

6 DATE OF BIRTH (month, day, and year) June 5 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .. min.
	43	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Housework (37)

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City Md.

PARENTS

10 NAME OF FATHER John Fischer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Dietz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Muller (Address) 137 S. Fifth St.

15 NOV 9 - 1920 ROBERT A. LAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1920

17 I HEREBY CERTIFY, That I attended deceased from 9/27/20 19.. to 11/5/20 19.. that I last saw her alive on 11/5/20 19.. and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum Exp.

(Signed) + Medical Examiner M. D.

(Address) 919 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Nov. 9th 1920.
20 UNDERTAKER	ADDRESS
Lilly & Julian.	403 S. Mo...

IMPORTANT. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D47911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120 D47911

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Henry Seitz

(a) RESIDENCE. No. Unknown ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

603

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records,
(Address) New City Hospital.

15 NOV 9 - 1920 ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 5, 1920

17 I HEREBY CERTIFY, That I attended deceased from November 29, 1905. to November 5, 1920.
that I last saw him alive on November 5, 1920.
and that death occurred, on the date stated above, at 8:20 P. m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis
(No cerebral hemorrhage)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis. (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) [illegible], M. D.

11/6/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 9th 1920
20 UNDERTAKER	ADDRESS
J. Ahearn & Co	2008 Eutaw

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047912

HEALTH DEPARTMENT—CITY OF BALTIMORE

047912

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 14 E. Cross St. 23 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J. Ranscher

(a) RESIDENCE. No. 14 E. Cross St. 23 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 17 '20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frank J. Ranscher Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Vincenzina Bracco

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y. N.Y.

14 Informant Mrs V. Ranscher

(Address) 14 E. Cross St.

15 Filed NOV 9 - 1920 19 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1920, to Nov 7, 1920, that I last saw h~~im~~ alive on Nov 7, 1920, and that death occurred, on the date stated above, at 8-30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. E. Campbell, M. D.

Nov 8, 1920 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Nov 9 1920

20 UNDERTAKER John S. Fearing & Co

ADDRESS 2008 Aliceanna

TION is very important. See instructions on back of certificates. ...at may be properly classified. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

D47913 HEALTH DEPARTMENT—CITY OF BALTIMORE D47913

CERTIFICATE OF DEATH. X 115

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary St.; 6 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Nisdorff Hoen

(Residence in Baltimore: No. Chrch Home & Infirmary, St.; 0 yrs., 0 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, October 31, 1868
(Month) (Day) (Year)

7-AGE, 62 yrs. 0 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)..... A. Hoen & Co.

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Ernest Hoen

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Frances E. Nisdorff

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Frank L Hoen-Son

(Address) 703 Union Trust Bldg

15- By ROBERT B. FRAUTER

Filed NOV 9 1920 191.... Burial Permit Issued

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 7, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27, 1920, to Nov. 7, 1920, that I saw h[illegible] alive on Nov. 7, 1920, and that death occurred, on the date stated above, at 1.15 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Prostate & Hydronephrosis Both Kidneys & Bladder

Pericarditis, acute & Effusion

Broncho-pneumonia (Duration)....yrs.....mos. 12 ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration)....yrs.....mos.....ds.

(Signed) Walter T. Anderson M. D.

Nov. 7, 1920. (Address) Church Home Balt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 12 ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Loxley, Balto. Co. Md.

Former or usual residence Loxley, Balto. Co. Md.

19-PLACE OF BURIAL OR REMOVAL, Green Mount Cemetery — DATE OF BURIAL, Nov. 9, 1920

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

Please read instructions on back of certificate. Statement of OCCUPATION is very

Spec. 6-9-19 H. P. Co.—1000 Pds.

1047914 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047914

80

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 Reservoir ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Cowgill Bartlett

(a) RESIDENCE. No. 604 Reservoir ST., 13 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 85 yrs 0 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Kemp Bartlett

6 DATE OF BIRTH (month, day, and year) May-19-1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Dover

(State or country) Delaware

PARENTS

10 NAME OF FATHER Ezekial Cowgill

11 BIRTHPLACE OF FATHER (city or town) Dover

(State or country) Delaware

12 MAIDEN NAME OF MOTHER Sarah Millechamp

13 BIRTHPLACE OF MOTHER (city or town) Milford

(State or country) Delaware

14 Informant Mrs. J. Kemp Bartlett (daughter-in-law)

(Address) 2406 N. Royal Terrace.

15 NOV 9 - 1920

Registrar ROBERT A. KRAUTH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb 20 1920 to interval, that I last saw her alive on November 7, 1920, and that death occurred, on the date stated above, at about 9 P.M. 1.35

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Attacks started 15 yrs ago

This attack lasted about 2 hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, Aldags.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No where

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No test

(Signed) Walter B Platt M. D.

, 19 (Address) 802 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friends Cemetery (Harford Road)	Nov 10 1920
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

TION is very important. See instructions on back of c

...be properly classified. Exact statement of OCCUPA-...k of certificates.

1947915 HEALTH DEPARTMENT—CITY OF BALTIMORE 1947915

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Mercy Hospital ST.: 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Max Schindler

(Residence in Baltimore: No. 2101 Westwood ave St.: 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH. Unknown (Month), 1 (Day) (Year)

7-AGE. 52 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clothing
(b) General nature of industry, business, or establishment in which employed (or employer): tailor

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Isaac Schindler

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Kala Fried

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1411 E Baltimore St

NOV 9 - 1920 ROBERT E KRAUTER

Filed....., 191.... Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 8 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

~~Pulmonary~~ Cerebral Hemorrhage Left.
(Hemorrhage due to arteriosclerosis)

Sudden (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner.)

Nov 9, 1920 (Address) 1657 Berg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mehrem Herring Run	11 9, 1920
20-UNDERTAKER Jack Lewis	ADDRESS 1411 E Balto

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

647916

HEALTH DEPARTMENT—CITY OF BALTIMORE

647916

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary

REGISTERED NO.

CITY OF BALTIMORE: (NO. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Minnie Peregoff

(a) RESIDENCE. NO. Whitelock & Brookfield ST., Edward Apts. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 33 ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~WIFE of~~ Wife of Mr Sam Peregoff

6 DATE OF BIRTH (month, day, and year) Nov 8, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Henry Bell 1411 E Balto

15 Filed NOV 9 - 1920 . 19 ROBERT P. BRAUER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 11, 1920 to Nov. 8, 1920

that I last saw her alive on Nov. 8, 1920

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 5, 1920

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W. T. anderson, M. D.

(Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 11-9 1920

20 UNDERTAKER Jack Lewis

ADDRESS 1411 E Balto

Now is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

047917 HEALTH DEPARTMENT—CITY OF BALTIMORE 047917

CERTIFICATE OF DEATH. 120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 65 Ann St.: 2 WARD)

2-FULL NAME Maggie Corns

(a) RESIDENCE. No. 65 S Ann St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 30 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
54				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Grodt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William E Corns
(Address) 65 Ann St

15 NOV 9 - 1920 ROBERT E KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1920, to Nov. 7, 1920, that I last saw h.e alive on Nov. 7, 1920, and that death occurred, on the date stated above, at 11 P, m.

The CAUSE OF DEATH* was as follows:

Chr. Int. Nephritis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilated Heart

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urinary

(Signed) C. B. Mottern, M. D.

, 19 (Address) 1711 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Nov 10 1920
20 UNDERTAKER	ADDRESS
Joseph Ahrens	221 N B Way

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47918 D47918

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2921 Guilford Av ST.; 12 WARD)

REGISTERED No. C 9-09

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Hoffman

(Residence in Baltimore: No. 2921 Guilford av St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, Oct. 11, 1852 (Month) (Day) (Year)

7-AGE, 68 yrs. 1 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Unemployed
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Kinsley

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M. Adams

(Address) 2921 Guilford Av

15 NOV 9 - 1920 ROBERT E KRAUTER
Filed....., 191.... Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 7th, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4th 1920, to Nov. 7th 1920, that I saw h[illegible] alive on Nov. 7th 1920, and that death occurred, on the date stated above, at 3.30 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ....yrs. ....mos. 4 ....ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(Duration) ....yrs. ....mos. ....ds.

(Signed) E. Jenetus Orem M. D.

Nov 8th, 1920 (Address) 2877 N Calvert St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, London Park Cem — DATE OF BURIAL, Nov. 9, 1920

20-UNDERTAKER Chas. E. Franck — ADDRESS 1012 Madison Av

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 47919

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47919

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 428 S Patterson Park Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia V Bowling

(a) RESIDENCE. No. 428 S Patterson Park Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Bowling

6 DATE OF BIRTH (month, day, and year) Dec. 16, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Fleming

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth McStay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Katherine Stewart
(Address) 428 S Patterson Pk ave

15 Filed NOV 9 - 1920 19 ROBERT E. LEE TYLER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 19 20

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1917, to Nov. 7, 1920, that I last saw h[illegible] alive on Nov 6, 1920, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Hostetter M. D.

11. 9. 1920 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery.	Nov. 10 19
20 UNDERTAKER	ADDRESS
E J Fanning & Son.	1938 Lafayette Ave

Be sure every item is properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47920 D47920 108

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hosp ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marjorie A. Bomberger

(a) RESIDENCE. NO. 2817 Kennedy Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 21 1904

7 AGE	Years	Months	Days
	16	2	16

If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Salisbury
(State or country) Md

PARENTS

10 NAME OF FATHER Wilmer R Bomberger

11 BIRTHPLACE OF FATHER (city or town) Bellefonte
(State or country) Pa

12 MAIDEN NAME OF MOTHER Annie L Stevens

13 BIRTHPLACE OF MOTHER (city or town) Salisbury
(State or country) Md

14 Informant Wilmer R Bomberger
(Address) 2817 Kennedy Ave

NOV 9 - 1920 ROBERT E LEANTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1920, to Nov 6, 1920, that I last saw h[illegible] alive on Nov. 6, 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Nov 6

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. Annis, M. D.

Nov 7, 19 (Address) 4 Gorsuch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov 9 1920
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

21 Nov '20

D 47921

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175 D 47921

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1 S Dr[illegible] St. or WARD) REGISTERED NO. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Johnson

(Residence in Baltimore: No. 6 Chaplin or ave Edgewood yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, white | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Feb Aug 20, 1835 (Month) (Day) (Year)

7-AGE 85 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired D 86
(b) General nature of industry, business, or establishment in which employed (or employer) Boiler Maker

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Samuel Johnson

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER Susan[illegible] Higgins

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William L. Johnson

(Address) 2017 E Fountain Ave

15-

NOV 9 — 1920 191 ROBERT A KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 7, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an[illegible] (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said[illegible] (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) M. D.

191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, MOUNT OLIVET. DATE OF BURIAL, NOV 9 — 1920 19....

20-UNDERTAKER JOHN F. DENNY ADDRESS 716 LIGHT ST.

Important. See instructions on back of certificate. ...may be properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47922 01 91

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2815 Elliott ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert Davis

(a) RESIDENCE. NO. 2815 Elliott ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred - yrs. - mos. 3 ds. How long in U. S., if of foreign birth? - yrs. - mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Nov. 5. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	-	-	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Jane Haynsworth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Thomas Davis (Address) 2815 Elliott St

15 Filed NOV 9 - 1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 8 1920

17 I HEREBY CERTIFY, That I attended deceased from 11 5, 1920, to 11 8, 1920

that I last saw him alive on 11 7, 1920

and that death occurred, on the date stated above, at 3. a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Oedema Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) H M Tilow M. D

11/8, 1920 Address) 315 S. Hughlandler

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Nov. 9 1920
20 UNDERTAKER Zirkler + Zirkler	ADDRESS 1739 E. Eager

Fill out all questions fully, legibly, and with ink. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D47923

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D47923

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906½ Pine St.; 18 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Williams

(Residence in Baltimore: No. 906½ Pine St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	colored	Single

6-DATE OF BIRTH, March 15, 1853
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
67 yrs. 7 mos. 25 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Dock

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Catherine Green

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Fannie Tetterson

(Address) 906½ Pine St.

15-

Filed....., 191.. ROBERT P. KNAUER

NOV 9 - 1920 Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 7, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 6 1920, to ..... 191...,
that I saw him alive on Nov. 6 1920,
and that death occurred, on the date stated above, at 1 a. m.
The CAUSE OF DEATH* was as follows:

Paralysis Cerebralis, Apoplexia

..... (Duration) ..... yrs. 1½ mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Tetterson M. D.

Nov. 7, 1920 (Address) 2326 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn	Nov. 10, 1920
20-UNDERTAKER Joseph A Merkell	ADDRESS 2516 Madison Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47924 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 120 D47924

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2733 Edmondson ST. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Levin T Hearn

(a) RESIDENCE. No. 2733 Edmondson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Fannie Hearn

6 DATE OF BIRTH (month, day, and year) May 2 - 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman 078

(b) General nature of industry, business, or establishment in which employed (or employer) Street Railway

(c) Name of employer United R. R. Co.

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Isaac T Hearn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Eliza Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Frances Hearn (Address) 2730 Edmondson Ave

15 NOV 9 - 1920 ROBERT F LEADER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1920

17 I HEREBY CERTIFY, That I attended deceased from October 25, 1920, to Nov 8, 1920, that I last saw h[illegible] alive on Nov 7, 1920, and that death occurred, on the date stated above, at 12. noon m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) autumn yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophy of Prostate Gland

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of February - 1920

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) C L Buxton, M. D.

11/9, 1920 (Address) 306 E Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov 9 1920
20 UNDERTAKER Geo W Little	ADDRESS 534 Fremont Ave

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

Chudzik

D47925 ✓ 1042 D47925

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 944 S. Clinton, ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Marie Chudzik

(Residence in Baltimore: No. 944 S. Clinton St.: ..... yrs., 2 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Sept. (Month) 6 (Day), 1920 (Year)

7-AGE, ... yrs. 2 mos. 2 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) child

9-BIRTHPLACE, (State or Country), Baltimore. Md.

PARENTS.

10-NAME OF FATHER, Bruno Hudzik.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Kathrin Mazkowski

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bruno Hudzik.

(Address) 944 S. Clinton St

15-

NOV 9 - 1920 191..... ROBERT F. KRAUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 8 (Day), 1920 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1 1920, to November 8 1920, that I saw h[er] alive on Nov. 8 1920, and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. ..... mos. ..... ds.

(Signed) Francis T. Sumpter M. D.

Nov. 8, 1920 (Address) 2431 Fait[illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary.	Nov. 10, 1920

20-UNDERTAKER	ADDRESS
M. F. Sadowski	705 S. Ann

Spec. 6-9-19—H. P. Co.—1000 Bks.

1047926 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047926

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Hayward (Haywood)

(a) RESIDENCE. No. 1935 Brunt St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chambermaid 070

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susie Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address) M.T.H.

NOV 9 - 1920 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 7 1920

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1919, to Nov. 7, 1920, that I last saw her alive on Nov. 6, 1920, and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. J. Rigney. M. D.

11-7-20. (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Nov 9 1920
20 UNDERTAKER Mrs Ida E Ellis	ADDRESS 1720 Maryland

THIS IS very important. See instructions on back of certificates. Exact statement of DECEPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47927

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47927

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 25 WARD)

2-FULL NAME Mr. J. P King

(a) RESIDENCE. No. Charleston, W. Va. ST. Ans WARD.
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 6 mos. ds. How long in U. S., if of foreign birth? [redacted] yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	W.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Unknown 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	74	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) "

14 Informant Mr J. A. King
(Address) Charleston, W. Va.

15 Filed NOV 9 - 1920 ROBERT J. BRAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1920, to Nov 8, 1920, that I last saw him alive on Nov 8, 1920, and that death occurred, on the date stated above, at 2:01 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardio renal sufficiency

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-4-20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. W. King M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charleston West Va	Nov 9 1920
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Calhoun St

Note.—It is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047928 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047928

CERTIFICATE OF DEATH.

X41

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. U.S PUBLIC HEALTH SERVICE HOSPITAL #56 ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fleming Foster Fort McHenry Baltimore Md.

(a) RESIDENCE. NO. Venter Virginia. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
24	yrs.	----	---	---

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant E. T. Rueneck Registrar
(Address) Fort McHenry Baltimore Md

15 NOV 9 - 1920 ROBERT P. CASTLE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/8 1920

17

I HEREBY CERTIFY, That I attended deceased from July 2, 1920 to Nov. 8 1920

that I last saw him alive on Nov. 8 1920

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum.

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

---- (duration) ---- mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of Sept. 9/20

Was there an autopsy? none

What test confirmed diagnosis? Exploratory laparotomy

(Signed) J. P. Reuneck M. D.

11/8 1920 (Address) Fort McHenry Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
King Williams Co Venter Va	Nov. 9 1920

20 UNDERTAKER D. Finson & Bro ADDRESS 1127 E Balto St

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

047929

HEALTH DEPARTMENT—CITY OF BALTIMORE

79 047929

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore General Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST.: 6 WARD)

2-FULL NAME Mrs. Minnie D. Hurkin

(a) RESIDENCE. No. 1634 E Balto St ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N J.

PARENTS

10 NAME OF FATHER Niman Hurman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Dr J. Hurkin

(Address) 1634 E Balto St

NOV 9 - 1920 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21 1920 to Nov. 8 1920, that I last saw h[illegible] alive on Nov. 8 1920, and that death occurred, on the date stated above, at 9.45 Pm,

The CAUSE OF DEATH* was as follows:

Carditis. over

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary infarct

(duration) yrs. mos. 2 hrs

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. C. Dohlhof, M. D.

, 19 (Address) E Balto Gen Hos

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philda Pa	Nov. 9. 1920
20 UNDERTAKER S. Lunatan & Bro	ADDRESS 1127 E Balto St

Important. See instructions on back of certificates. Exact statement of OCCUPA. is very important. as properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47930 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47930

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3125 Guilford ave ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Winifred Smyth

(a) RESIDENCE. No. 3125 Guilford Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married ~~Married~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph. Smyth

6 DATE OF BIRTH (month, day, and year) May 31st 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William P. Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary Clarke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

11 Informant William P. Ryan

(Address) E. Baltimore St

NOV 9- 1920

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11- 7 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1920, to Nov. 7, 1920, that I last saw her alive on Nov 6, 1920, and that death occurred, on the date stated above, at 12.20 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis Valvular disease

(duration) 3 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. W. Gehrig, M. D.

, 19 (Address) 622 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Nov 10 1920
20 UNDERTAKER	ADDRESS
John A. Moran	3000 E. Balto St.

THIS IS very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.47931 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47931

CERTIFICATE OF DEATH. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Aged Womens Home (ST.:) 19 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A. Smith

(a) RESIDENCE. No. 1400 N Lexington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 6 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Wht	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 18 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Jollicoffer M.D.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sarah Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Ella J Jones Matron
(Address)

15 Filed 9-1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 19 20, to Nov 8, 19 20, that I last saw h alive on Nov 8 19 20, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T J Norwood, M. D.

, 19 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wm. Market Md	Nov 10 1920

20 UNDERTAKER Geo J Smith ADDRESS 1000 W Fayette

THIS IS very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.47932 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47932

CERTIFICATE OF DEATH.

REGISTERED NO. C 67

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1828 Belt St. St.; 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Clinton Cooke

(Residence in Baltimore: No. 1828 Belt St.) St.; 57 yrs., 6 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) (married)

6-DATE OF BIRTH, 4 (Month) 17 (Day), 1863 (Year)

7-AGE, 57 yrs. 6 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) 031

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Joel M. Cooke

11-BIRTHPLACE OF FATHER (State or Country), West Pom Pa

12-MAIDEN NAME OF MOTHER Ann R Harris

13-BIRTHPLACE OF MOTHER (State or Country), West Pom Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Jas. E. Cooke

(Address) 1828 Belt St

15- Filed 1920, Robert P. Harrison, 191..... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 8 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 6.21 1919, to Nov. 8 1920, that I saw h[illegible] alive on 11.8 1920, and that death occurred, on the date stated above, at 12.01 m.

The CAUSE OF DEATH* was as followa:

Paralysis of Insane

Paresis

(Duration) 7 Weeks

CONTRIBUTORY (Secondary) Chronic Gastritis Chronic

(Duration) yrs. 18 mos. ds.

(Signed) T. F. Turlington M. D.

11.8., 1920 (Address) 1026 E Fort Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem. DATE OF BURIAL, Nov. 10, 1920

20-UNDERTAKER W J Fielding ADDRESS Fort & Patterson Pl

Instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

~~1~~ 047933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 047933

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Pinnell

(a) RESIDENCE. No. 918 S Calhoun St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 11 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER George Dimeler

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER May Froverty

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Hospital Record
(Address) J. H. H.

15 NOV 10 1920 ROBERT B FRAZIER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9th 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 28th 1920, to Nov 9th 1920, that I last saw ~~him~~ alive on Nov 9th 1920, and that death occurred, on the date stated above, at 3A-0 m.

The CAUSE OF DEATH* was as follows:

Diarrhea (not dysentery)
Jaundice

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? No

(Signed) [illegible] M. D.

, 19 (Address) J H H Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lutheran Cem Catonsville	Nov 10 1920
20 UNDERTAKER Robert Bonderman	ADDRESS 17 S Calhoun

TION is very important. See instructions on back of certificates. ...t may be properly classified. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Blks.

D47934

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47934

151

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 Asquith St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Schwindel

(Residence in Baltimore: No. 1022 Asquith St.; ... yrs., ... mos. ... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR ~~DIVORCED~~, (~~Write~~ the word.) Single

6-DATE OF BIRTH, July 7, 1930 (Month) (Day) (Year)

7-AGE, ... yrs. 4 mos. 2 da.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ...
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Geo J. Schwindel

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER, Minnie Reed

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. Schwindel

(Address) 1022 Asquith St

15-NOV 10 1920 Filed ... 191... ROBERT E KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 9, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1920, to Nov 9 1920, that I saw h[illegible] alive on Nov 9 1920, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Pneumonia

(Duration) ... yrs. 6 mos. ... da.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... da.

(Signed) Chas. E. Lemmon M. D.

Nov 9, 1920 (Address) 1412 Eager St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem

DATE OF BURIAL, Nov. 11, 1920

20-UNDERTAKER Henry Strack Son

ADDRESS 1321 E Eager St

Instructions on back of certificate.

10.3 r 11.30 7 Chandler S 599

Spec.—6-9-19—H. P. Co.—1000 Bks.

L47935 HEALTH DEPARTMENT—CITY OF BALTIMORE L47935

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1231 Battery Ave ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John George Steiler

(a) RESIDENCE NO. 1231 Battery ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 4 1875.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Grocer.

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 034

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Rochus Steiler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Beichert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Edward Steiler 1231 Battery ave

15 Filed NOV 10 1920 ROBERT B LEAVER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 3rd, 1920, to Nov 6, 1920, that I last saw him alive on Nov 6, 1920, and that death occurred, on the date stated above, at 11.20 P. m.

The CAUSE OF DEATH* was as follows:

General Debility. ovw

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) C. E. Buxton, M. D.

11/8-1920 (Address) 301 East Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A & Co	11-10 1920
20 UNDERTAKER	ADDRESS
Edward B Hanley	115 E West St

HON. is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

Pickert

D47936

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47936

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 S. Lakewood av ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wladyslaw Pickut

(Residence in Baltimore: No. 802 S. Lakewood av St.; ...yrs.,...mos.,...ds.)

Lakewood.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, August (Month) 23 (Day), 1920 (Year)

7-AGE, ...yrs. 2 mos. 16 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Pickut

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Michalina Maselbas

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Pickut

(Address) 802 S. Lakewood av

15- NOV 10 1920 Filed ..., 191... BOBERT F. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 9 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 2 1920, to November 2 1920, that I saw h[illegible] alive on November 2 1920, and that death occurred, on the date stated above, at 1[illegible] p. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ...yrs. ...mos. 6 ds.

CONTRIBUTORY (Secondary) Diarrhea

(Duration) ...yrs. ...mos. 3 ds.

(Signed) [illegible] M. D.

Nov. 9, 1920 (Address) 722 S. Ann av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Nov. 10, 1920
20-UNDERTAKER	ADDRESS
John M. Weber	1803 Bank St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047937 HEALTH DEPARTMENT—CITY OF BALTIMORE 047937

104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 S. Harris Alley 12th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Ida Brandt

(a) RESIDENCE. No. 906 S. Harris Alley 12th WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 24 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
—	—	—	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) (infant)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER August Brandt

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Schmied

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Maryland

14 Informant W^m Brandt (Grandfather)
(Address) 906 S. Harris alley

15 Filed NOV 10 1920 ROBERT [illegible] Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1920, to Nov 10, 1920, that I last saw her alive on Nov 9, 1920, and that death occurred, on the date stated above, at 5.45 A. m.

The CAUSE OF DEATH* was as follows:

Exhaustion — (Starvation)

(duration) ... yrs. ... mos. — ds.

CONTRIBUTORY (Secondary) Mal-nutrition — Bottle fed — gastro enteritis (duration) ... yrs. ... mos. 24 ds.

18 Where was disease contracted
If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

Nov 10, 1920 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st German	Nov 11 1920
20 UNDERTAKER	ADDRESS
Peter Nicolaus	2046 Eastern

IRON is very important. See instructions on back of certificates. Exact statement of OCCUPA-

D47938 HEALTH DEPARTMENT—CITY OF BALTIMORE 79 D47938

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2129 Woodbery ave ST.: 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. Humphreys

(Residence in Baltimore: No. 2129 Woodberry Ave 84 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Feb. 26, 1853
(Month) (Day) (Year)

7-AGE, 67 yrs. 8 mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 637

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Thomas Casey

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Seth Humphreys

(Address) 2129 Woodberry Ave

15- NOV 10 1920 191... ROBERT J. SLATER Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 8, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (autopsy or inquiry) thereon and from the evidence obtained by said inquest (autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy
Valvular disease of heart
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) John Thomsen M. D.
(Coroner)
Nov 8 1920 (Address) 3632 Roland ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine — DATE OF BURIAL, Nov. 11, 1920

20-UNDERTAKER Horace Bunguson — ADDRESS 3631 Fulton Ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

447939 HEALTH DEPARTMENT—CITY OF BALTIMORE 447939

CERTIFICATE OF DEATH. 170

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 809 McKim ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvestri Nicholas

(a) RESIDENCE. No. 809 McKim ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Liv in Balt-10 yrs Na

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Robert A Elliott

(Address) 1735 Ashland Av

15 Filed NOV 10 1920 19 ROBERT J. BRADLEY Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1920, to Nov 8, 1920, that I last saw him alive on Nov 8, 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Robt J Green, M. D.

11-10, 1920 (Address) 120½ Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Keswick Va	Nov 11 1920
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	1735 Ashland Av

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified. ...ould state

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47940

CERTIFICATE OF DEATH.

41 D47940

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2608 E. Oliver St.: 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William McCleester

(a) RESIDENCE. No. 2608 E. Oliver St., 8 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 6 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Danl McCleester.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Sarah Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant
(Address) 2608 E. Oliver St.

15 Filed NOV 10 1920, 19 ... Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1919, to Nov 8, 1920
that I last saw h alive on Nov 8, 1920.
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:

Cancer of Descending Colon

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

15 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 8

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. E. Hamer, M. D.

Nov. 9 1920 (Address) 1301 N Patterson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Nov. 11 1920
20 UNDERTAKER Lilly and Zeller	ADDRESS 403 N Howard St.

NOTICE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47941

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47941

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2215 Eastern Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Regina Seitz

(a) RESIDENCE. No. 2215 Eastern Ave ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 11 mos. ds. How long in U. S., if of foreign birth? 64 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Seitz.

6 DATE OF BIRTH (month, day, and year) Nov 18th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Kellner.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Hammelbacher.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Joseph Seitz. (Address) 2215 Eastern ave.

NOV 10 1920 ROBERT E KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9th 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 19.. to Nov 8 1920, that I last saw h[er] alive on Nov 5 19.., and that death occurred, on the date stated above, at 12 [illegible] a m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis? Physical Diagnosis

(Signed) [illegible] M. D.

19 (Address) 1437 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Nov 13 1920
20 UNDERTAKER Lilly & Zeller	ADDRESS 403 S Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Maynard Rhodes.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 47942

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 47942

CERTIFICATE OF DEATH.

X 76

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.; 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maynard Rhodes

(a) RESIDENCE. No. Laurel St., Md Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Boy

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 5-1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Laurel Md

PARENTS

10 NAME OF FATHER Maynard Rhodes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Laurel Md.

12 MAIDEN NAME OF MOTHER Rae Tilghman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cordova Md

14 Informant Sarah E. Tilghman

(Address) Laurel Md.

15 Filed NOV 1920, 19 ROBERT E. LEAVELL. Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1920, to Nov 9, 1920, that I last saw h alive on November 9, 1920, and that death occurred, on the date stated above, at 7-15 m.

The CAUSE OF DEATH* was as follows:

Lobar Sinus Thrombosis coma

(duration) yrs. mos. 0 ds.

CONTRIBUTORY (Secondary) Embolism 1 hr

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of Nov 8

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) J. O. Bedsel, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md.

DATE OF BURIAL Nov 11 1920

20 UNDERTAKER J. J. Fahey & Son

ADDRESS 1316 Light

IMPORTANT: Physicians should state plainly the full name, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D47943

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47943

CERTIFICATE OF DEATH.

120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 Eastern ave ST.: 1 WARD)

2-FULL NAME Amelia Weigel

(a) RESIDENCE. No. 2108 Eastern Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Christian Joseph Weigel

6 DATE OF BIRTH (month, day, and year): January 20th 1855

7 AGE: Years 65 | Months 9 | Days 20 dys | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boarding lady 086

(b) General nature of industry, business, or establishment in which employed (or employer): Packing House

(c) Name of employer: John Boyle Co.

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Wiedenhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Dr. Amelia E. Luitz
(Address): 1717 N. Caroline St.

15 Filed ..... 19 ..... ROBERT B. KRAUTER Registrar

NOV 10 1920 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 8th 1920

17 I HEREBY CERTIFY, That I attended deceased from October 23rd 1920, to November 8th 1920, that I last saw h[illegible] alive on November 6th 1920, and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis,
Acute Myocarditis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Uremia + Collapse

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Urinary Analyses

(Signed) Amelia E. Luitz, M. D.

19 (Address) 1717 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz

DATE OF BURIAL: Nov 12 - 1920

20 UNDERTAKER: William Cook

ADDRESS: 502 E. North

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47944

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47944

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 Franklin Terrace ST.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Blair Essing

(a) RESIDENCE. No. 529 Franklin Terrace ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27- 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	-	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Milliner 086

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): New York City.

PARENTS

10 NAME OF FATHER: Charles E. Essing

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret T. Blair

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant (Address): Charles E. Essing 529 Franklin Terrace.

15 NOV 10 1920 ROBERT H. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1920

17 I HEREBY CERTIFY, That I attended deceased from October 25, 1920, to Nov. 7, 1920, that I last saw her alive on November 7, 1920, and that death occurred, on the date stated above, at 10:00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis with pulmonary hemorrhage.

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? 4725 Locust Ave.

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical examination

(Signed) H. E. Wright, M. D.

11/8, 1920 (Address) 728 E. 41st. Street.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Nov. 11 - 1920

20 UNDERTAKER: William Cook — ADDRESS: 5025 North Ave.

TION is very important. See instructions on back of certificates.

D47945 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D47945

CERTIFICATE OF DEATH. 159

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1615 John St. St. 14 WARD) REGISTERED No. C

2-FULL NAME Ida Skinder (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1615 John St. 68 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, unknown (Month) (Day) 1860 (Year)

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none 100
(b) General nature of industry, business, or establishment in which employed (or employer). Retired housekeeping

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Jacob Tibbels

11-BIRTHPLACE OF FATHER (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. H. Tibbels Jr.

(Address) 891 W. Fayette St.

15- NOV 10 1920 Filed ..... 191.. ROBERT J. KRAUTER Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 9, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by inhalation of illuminating gas. about 1/2 hr.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. D. Hennessy M. D. (Coroner.)

November 10 1920 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount DATE OF BURIAL, 11—11—, 1920

20-UNDERTAKER W. C. Brenning Son ADDRESS 317 N. Schroeder St

IMPORTANT. PHYSICIANS should state plainly and fully the CAUSE OF DEATH, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-8-19 H. P. Co.—1060 Bks.

047946 HEALTH DEPARTMENT—CITY OF BALTIMORE 047946

CERTIFICATE OF DEATH.

REGISTERED NO. 25 - 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Murphy

(a) RESIDENCE. No. 6th st., Fairfield St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Oklahoma

PARENTS

10 NAME OF FATHER Alexander Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Augusta Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M.T.H.

15 NOV 10 1920 ROBERT J. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5th 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1st, 1920, to Nov. 5th, 1920, that I last saw him alive on Nov. 4th, 1920, and that death occurred, on the date stated above, at 3 A. .m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) [illegible] M. D.

11-5-20, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19 1920
20 UNDERTAKER	ADDRESS

NOV 1 1920

Commissioner Health

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified. Space must be filled in. Do not use abbreviations. Should state

D.47947 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47947

CERTIFICATE OF DEATH.

175-001

1-PLACE OF DEATH Essex & Fallsway Rear 1 REGISTERED NO. C

CITY OF BALTIMORE (No. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Peenski

(Residence in Baltimore: No. 2234 Essex St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Infant

6-DATE OF BIRTH, April 10th (Month) (Day), 1915 (Year)

7-AGE, 5 yrs. 7 mos. 8 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Michael Peenski

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Helen Bowensky

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Peenske

(Address) 2234 Essex St

15- Filed NOV 10 1920, 191 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 8 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Run by Auto

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Lynn Crosby M. D. (Coroner)

11/10, 1920. (Address) 1400 Gittings St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Marys Irapped	Nov 11th, 1920
20-UNDERTAKER	ADDRESS
Wendel Kippeldorf	372 S. Ann St

IMPORTANT. See instructions on back of certificate. PHYSICIANS should state exactly. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.47948

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47948

CERTIFICATE OF DEATH.

120 REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 518 Archer St. 21 WARD)

2-FULL NAME William Keller

(Residence in Baltimore: No. 518 Archer St.; yrs., 64 mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH: July 31st, 1856 (Month) (Day) (Year)

7-AGE: 64 yrs. 3 mos. 9 da.

If LESS than 1 day. ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sand Paperer
(b) General nature of industry, business, or establishment in which employed (or employer): Wm Hughes Est Co

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Henry Keller

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar Reinhardt

(Address) 518 Archer Street

15- Robert P [illegible]

Filed NOV 10 1920 191 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 9, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Par. Nephritis

(Duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) Geo Edwin Wade M. D.
(Coroner)

Nov 10, 191... (Address) 143 N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Nov. 12, 1920

20-UNDERTAKER: Joseph L. Cook — ADDRESS: 1003 W. Balto St.

Important. See instructions on back of certificate.

D.47949

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.47949

CERTIFICATE OF DEATH.

17V

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital 20 WARD)

2-FULL NAME Robert E. Bellert.

(Residence in Baltimore: No. 442 Farrow St.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

21 St.; yrs., 8 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb 21st, 1899
(Month) (Day) (Year)

7-AGE, 21 yrs. 8 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Sheet Metal Worker.
(b) General nature of industry, business, or establishment in which employed (or employer) 184

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Rudolph DeLeet

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Knopp

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Edna F. DeLeet

(Address) 442 Farrow St

15- Robert F. Harrison,

Filed ..... 1920 Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 8, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fall from Scaffold

(Duration) ... yrs. ... mos. 1 ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ... yrs. ... mos. 1 ... ds.

(Signed) G. C. Blake M. D.
(Coroner.)

1921 (Address) 7 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem

DATE OF BURIAL, Oct 11th, 1920

20-UNDERTAKER Joseph B. Cook

ADDRESS 1003 W. Balto St

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very ... may be properly classified. PHYSICIAN should state ... so that it may be ...

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.47950

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.47950

CERTIFICATE OF DEATH.

81

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. German Aged Home ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Herz

(a) RESIDENCE. No. Baltimore & Payson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 7 mos. ds. How long in U. S., if of foreign birth? 30 yrs. 7 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1832

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
88	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hessen
(State or country) Germany

PARENTS

10 NAME OF FATHER Heinrich

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna L. Richer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Records German Aged Home
(Address) Baltimore & Payson St.

15 Filed .19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1st, 1920, to Nov. 9th, 1920, that I last saw him alive on Nov. 8th, 1920, and that death occurred, on the date stated above, at 11.40a m.

The CAUSE OF DEATH* was as follows:

Arteio Sehlerosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatic - Clinical

(Signed) John Nauff. M. D.

.19 (Address) 1843 W. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov. 11 1920
20 UNDERTAKER Joseph L. B. Cook.	ADDRESS 1003 W. Balto Street

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47951 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47951

CERTIFICATE OF DEATH.

37

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. St.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. John Moran

(a) RESIDENCE. No. 27 N. Liberty St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 2 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 9, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 032

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Andrew Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Molly ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) America

14 Informant Mrs. Frank Morgan (Address) 1526 Jackson St

15 Filed Robert P. Harrison, Registrar

1920 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/8 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 8, 1920, to Nov. 8, 1920, that I last saw him alive on 11/8, 1920, and that death occurred, on the date stated above, at 7.40 p. m.

The CAUSE OF DEATH* was as follows:

Taken Donsalis

Nov.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Irma L. Ridgely, M. D.

11/8, 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Nov. 11 1920
20 UNDERTAKER	ADDRESS
F. C. Keane & Son	739 Hanover St

TION is very important. See instructions on back of certificates.

...certificate may be properly classified. Exact statement of OCCUPA-

D. 47952

D. 47952

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

H1

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1436 Patapsco ST.: 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Hughes

(a) RESIDENCE. No. 1436 Patapsco ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michl Hughes

6 DATE OF BIRTH (month, day, and year): 1857

7 AGE — Years: 63 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 000

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patrick Barrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Rape

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Leo. W. Hughes
(Address): 1436 Patapsco.

15 Filed . 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/5/20 19

17 I HEREBY CERTIFY, That I attended deceased from 11/1/20, 19, to 11/5/20, 19, that I last saw h W alive on 11/3/20, 19, and that death occurred, on the date stated above, at 1:30 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Carcinoma Coecum

(duration) yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? mass in right lower abdomen

(Signed) Jas. A. Donnelly M.D.

11/9, 1920 (Address) 1072 N. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem.

DATE OF BURIAL: Nov 11 1920

20 UNDERTAKER: F. A. Trader & Son

ADDRESS: 739 Fayette

Please is very important. See instructions on back of certificates.

D.47953

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.47953 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1163 W. Hamburg ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B Dolphin

(a) RESIDENCE. No. 1163 W. Hamburg ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline E Dolphin

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Frank Dolphin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Anna M Norton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Stella Dolphin

(Address) 1163 W. Hamburg st

15 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-8 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1920, to Nov 8, 1920, that I last saw him alive on Nov 7, 1920, and that death occurred, on the date stated above, at 7.50 a m.

The CAUSE OF DEATH* was as follows:

Hemorrhage Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Grandbois, M. D.

11/10, 1920 (Address) 517 Leadenhall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 13 1920
20 UNDERTAKER	ADDRESS
F. C. Frances & Son	703 Hanover

NOV 10 1920

THIS is very important. See instructions on back of certificates. Be sure to state properly classified. Exact statement of OCCUPA-

Spec.—5-9-19—H. P. Co.—1000 Blks.

D.47954 HEALTH DEPARTMENT—CITY OF BALTIMORE D47954

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Academy St. 28 WARD) 120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Umphreys

(a) RESIDENCE. NO. 8 Academy ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel J Umphreys

6 DATE OF BIRTH (month, day, and year) Oct 16 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD

PARENTS

10 NAME OF FATHER John Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) MD

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mary E Canapp

15 Filed NOV 10 1920, 19 Robert F. Harrison, Registrar
(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1920, to Nov 8 1920, and last saw h[illegible] alive on Nov. 8 1920, and that death occurred, on the date stated above, at 12 15 A.M.

The CAUSE OF DEATH* was as follows: Chronic Interstatial Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) C. C. Hargett, M. D.

, 19 (Address) 5 W. E. Cold.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Nov 11 1920

20 UNDERTAKER	ADDRESS
Cheswoth & Chestnut	

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.47955 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.47955

CERTIFICATE OF DEATH. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 E. 27th ST. 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard H. Riley

(a) RESIDENCE. No. 404 E. 27. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb. 28. 1916

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
4	8.	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto city (State or country) md.

PARENTS

10 NAME OF FATHER Anthar Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Edna Straub

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Edna. Riley (Address) 404 E. 27 St.

15 Filed NOV 10 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 19 20

17 I HEREBY CERTIFY, That I attended deceased from Nov 7 , 1920, to Nov 10 , 1920, that I last saw him alive on Nov 10 , 1920, and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia incip

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gunter N. Dey

(Signed) L. A. Richardson M. D.

(Address) 1127 W. 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	11/11/ 1920
20 UNDERTAKER Chenowith & Son.	ADDRESS 3617 Chestnut ave

...TION is very important. See instructions on back of certificates. ...may be properly classified. ...Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

20.47956 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.47956

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 Rosebank ave ST.; 27 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy Catherine Gantz

(Residence in Baltimore: No. 313 Rosebank ave St.; 21 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	white	single

6-DATE OF BIRTH. June (Month) 11 (Day), 1886 (Year)

7-AGE.	If LESS than 1 day,
34 yrs. 4 mos. 28 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE. (State or Country). Chicago Ill.

PARENTS.

10-NAME OF FATHER. George C. Gantz

11-BIRTHPLACE OF FATHER (State or Country). Ohio

12-MAIDEN NAME OF MOTHER Mary Jane Nutting

13-BIRTHPLACE OF MOTHER (State or Country). Mass.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Gertrude G. Gatchell

(Address) 313 Rosebank ave

15- Robert P. Harrison,

OV 10 1920 ...., 191.....

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 9 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 5 1920, to Nov. 9 1920, that I saw her alive on Nov. 9 1920, and that death occurred, on the date stated above, at 5.45 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
double

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jno. A. Foutcher M. D.

....., 191... (Address) 1025 Mad ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Presbyterian Cemetery Hoc Ans. DATE OF BURIAL. Nov. 11, 1920

20-UNDERTAKER Chas. G. Black ADDRESS 742 W. North ave

Please write plainly. Read instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D.47957 HEALTH DEPARTMENT—CITY OF BALTIMORE D.47957

CERTIFICATE OF DEATH.

REGISTERED NO. C 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S Harris ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katie Hadomazki

(Residence in Baltimore: No. 319 S Harris St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Sept 18, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 22 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Weselin Hadomazki

11-BIRTHPLACE OF FATHER (State or Country) Serbia

12-MAIDEN NAME OF MOTHER Milica Subich

13-BIRTHPLACE OF MOTHER (State or Country). Serbia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Weslein Hadomazki

(Address) 319 S. Monroe St

15- NOV 10 1920 Robert P. Harrison,
Filed ....., 191.... Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 10, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 5 1920, to Nov 9 1920, that I saw her alive on Nov 9 1920, and that death occurred, on the date stated above, at 11:55 a.m.

The CAUSE OF DEATH* was as follows:

Enteric-Colitis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 2 ds.

(Signed) Fred B Jewett M. D.

Nov 10, 1920 (Address) 2516 Barclay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park	Nov 11th 1920
20-UNDERTAKER	ADDRESS
A. Jones	204 S. Stricker St

See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047958

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047958

CERTIFICATE OF DEATH.

64-091

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 800 Chauncy Ave ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elias Rosenberg

(a) RESIDENCE. No. 800 Chauncy Ave ST., ..WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced (write the word)~~
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Myer Rosenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Pauline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant E Buttenwieser
(Address) 800 Chauncy Ave

15 Filed NOV 11 1920 ROBERT P. BRAUER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 10, 1920, to Nov. 10, 1920, that I last saw him alive on Nov 9, 1920, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. Frederick Lentz, M. D.

11/16 1920 (Address) 7040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cemet	Nov. 11 1920
20 UNDERTAKER Sol Grinson	ADDRESS 1919 Madison Ave

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified. Exact statement of OCCUPATION should state

Spec.—8-24-14—M. & T.—2000 Bks.

Lucy Gale

1947959

HEALTH DEPARTMENT—CITY OF BALTIMORE

1947959

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 403 N Pine St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy Gale

(Residence in Baltimore: No. 403 N Pine St.; 24 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1896 (Year)

7-AGE,	If LESS than 1 day,
24 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country) Balto City

PARENTS.

10-NAME OF FATHER, Frank Gough

11-BIRTHPLACE OF FATHER (State or Country) Md

12-MAIDEN NAME OF MOTHER Lucy Bennett

13-BIRTHPLACE OF MOTHER (State or Country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Pennsa ave

NOV 11 1920 ROBERT F. KRAUTER

Filed....., 191.. Registrar of Vital Statistics.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 8, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 24 1920, to Nov 8 1920, that I saw h[illegible] alive on Nov 8 1920, and that death occurred, on the date stated above, at 1[illegible] m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... Interstitial Nephritis

..... (Duration) ..... yrs. 3 mos. 5 ds.

CONTRIBUTORY (Secondary) Stomatitis

..... (Duration) ..... yrs. ..... mos. 9 ds.

(Signed) ..... Frank M Gannon ..... M. D.

Nov 11, 1920 (Address) 322 N Gaines

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cem	Nov. 11, 1920
20-UNDERTAKER	ADDRESS
Daniel Easton	916 Pa ave

Important. See instructions on back of certificate. Name and statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47960

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47960

CERTIFICATE OF DEATH.

91-081

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Veazie

(a) RESIDENCE. No. 205 E. Montgomery St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework ooo

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): New York.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records,
(Address) New City Hospital.

NOV 11 1920 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 9, 1920

17 I HEREBY CERTIFY, That I attended deceased from September 9, 19 19 to November 9, 19 20.

that I last saw her alive on November 9, 19 20.

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arterio - sclerosis (no cerebral hemorrhage) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test

(Signed) [illegible] M. D.

11/10/20 (Address) New City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Nov 11 1920
20 UNDERTAKER David Easton	ADDRESS 916 E Pratt

TION is very important. See instructions on back of certificates.

...it may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47961 HEALTH DEPARTMENT—CITY OF BALTIMORE D47961

37

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST.; 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Johnson

(a) RESIDENCE. No. 310 Bartel Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of ? (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
66	yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bay View Hosp. Records (Address)

15 Filed NOV 11 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1920

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to Nov 10, 1920, that I last saw him alive on Nov 9, 1920, and that death occurred, on the date stated above, at 8:05 P m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection ?

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Serological + Clinical data

(Signed) Wm. B. C. Medairy, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Nov 13 1920
20 UNDERTAKER Daniel Easby	ADDRESS 946 Lan

TION is very important. See instructions on back of certificates.

at it may be properly classified. Exact statement of OCCUPA-

1047962 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047962

CERTIFICATE OF DEATH. X 183

1 PLACE OF DEATH City of Baltimore (No. Franklin Square Hospital St.: 16 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Louisa Moore.

(Residence in Baltimore: No. 1023 Rice St.

St.; yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH, ... (Month) Unknown (Day) ....., 1903 (Year)

7-AGE, ... 17 ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Jacksonville Fla

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Florida

12-MAIDEN NAME OF MOTHER Mary Bolden

13-BIRTHPLACE OF MOTHER (State or Country), Florida

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Stewart

(Address) Trenton N.J.

15- Filed NOV 11 1920, 191. ROBERT E KRAUTER Burial Permit Officer.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. (Month) 6 (Day) ....., 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon And from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Wounds Inflicted by Ax

..... (Duration) ... yrs. ... mos. 2 hrs.

CONTRIBUTORY (Secondary) Hemorrhage

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) H. Blade M. D.

(Coroner) 143 N. Bway

Nov 11, 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Jacksonville Fla.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Jacksonville Fla	Nov 11, 1920
20-UNDERTAKER	ADDRESS
Samuel T Hensley	578 N Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bka.

D47963

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47963

82-091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

2-FULL NAME Annie Truly

(a) RESIDENCE. No. Unknown ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	about 65 Unknown			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed NOV 11 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 8 1920

17 I HEREBY CERTIFY, That I attended deceased from November 1, 1920. to November 8, 1920.

that I last saw her alive on November 7, 1920.

and that death occurred, on the date stated above, at 12:20 A.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis with cerebral thrombosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis? No especial test.

(Signed) V Sherman. M. D.

11/8/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11/11 1920
20 UNDERTAKER Samuel T Kennedy	ADDRESS 578 W Biddle

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47964 HEALTH DEPARTMENT—CITY OF BALTIMORE D47964

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. [illegible] WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Garland

(a) RESIDENCE. NO. 904 Madison Ave. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER Wm. Garland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Lucy Barnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant Hospital Records (Address) [illegible] H.

15 Filed NOV 11 1920, 19 ROBERT J. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1920, to Nov. 5, 1920, that I last saw him alive on Nov. 5, 1920, and that death occurred, on the date stated above, at 3.05 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. 2 mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) S.J. Asgey, M. D.

11-5-20 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	11 11 1920
20 UNDERTAKER Samuel T. Hemsley	ADDRESS 578 N. Bridle

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

119 / 047965

047965

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 N. Eutaw ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Rodgers

(a) RESIDENCE. No. 926 N. Eutaw ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown 1867

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs Lucy Robinson
(Address) 927 Eutaw Ave

15 NOV 11 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/9/1920

17 I HEREBY CERTIFY, That I attended deceased from 10/28, 1920, to 11/9, 1920, that I last saw h.. alive on Nov. 8, 1920, and that death occurred, on the date stated above, at 3:55 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) acute nephritis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Jno H Tompkins, M. D.

, 19 (Address) 1019 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	11/12 1920
20 UNDERTAKER Samuel F Kennedy	ADDRESS 578 N Eutaw

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition

Spec.—6-9-19—H. P. Co.—1000 Bka.

Thorald P. Sims

1047966

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047966

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Laurens ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thorald Pinkney Sims,

(a) RESIDENCE. NO. 1704 Laurens ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Mar. 24 - 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Mt. Wash, Balto. Co.
(State or country) Md. U.S.A.

PARENTS

10 NAME OF FATHER Thos. E. Sims,

11 BIRTHPLACE OF FATHER (city or town) Calvert Co.,
(State or country) Md

12 MAIDEN NAME OF MOTHER Laura Padmore

13 BIRTHPLACE OF MOTHER (city or town) Demosarra, B.G.
(State or country) South America

14 Informant Mrs. Ella E. Padmore
(Address) 517 - 17th St. N.W.

15 NOV 11 1920 ROBERT E. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9th 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov. 9th, 1920, to Nov. 9th, 1920, that I last saw him alive on Nov 9th, 1920, and that death occurred, on the date stated above, at 7.20 8. m.

The CAUSE OF DEATH* was as follows:

Acute Congestion
Bronchopneumonia

(duration) 1 yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Balto.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology.

(Signed) James Faboard Bell, M. D.

, 19 (Address) 1205 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Md Auburn Cmty	Nov. 11th 1920

20 UNDERTAKER George H. Holland ADDRESS 1631 Druid Hill Ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

1947967 HEALTH DEPARTMENT—CITY OF BALTIMORE 1947967

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE: (No. 1711 Byrd ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia K Strobel

(Residence in Baltimore: No. 1711 Byrd St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sing'e

6-DATE OF BIRTH, Sept 29, 1919
(Month) (Day) (Year)

7-AGE, 1 yrs. 1 mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Co

PARENTS.

10-NAME OF FATHER, Wm Strobel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Koegel

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Strobel

(Address) 1711 Byrd

15-NOV 11 1920 ROBERT P KRAUTER

Filed....., 191.... Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 9, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1920, to Nov 9 1920, that I saw h[illegible] alive on Nov 9 1920, and that death occurred, on the date stated above, at 5. P m.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration).....yrs.....mos. 30 ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) J H Courtney M. D.

Nov 10, 1920 (Address) 2100 Huntingdon Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery

DATE OF BURIAL, Nov. 11th, 1920

20-UNDERTAKER E. J. Fanning & Son

ADDRESS 1460 Battery Ave.

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

047968 HEALTH DEPARTMENT—CITY OF BALTIMORE 047968

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 So Gilmor 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lidy J Bruchey

(a) RESIDENCE. No. 404 So Gilmor WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Bruchey

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Va

12 MAIDEN NAME OF MOTHER Fanny Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) — Va

14 Informant James H Bruchey (Address) 404 So Gilmor

15 Filed NOV 11 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 19 20

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 19 19, to Nov 8, 19 20, that I last saw h[illegible] alive on Nov 8, 19 20, and that death occurred, on the date stated above, at 8.55 m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis + Diabetes

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Uremia

Coma (duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Thos Feldenkirk M. D.

Nov 10, 19 20 (Address) 30 So Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 11th 1920
20 UNDERTAKER John Heaman & Son	ADDRESS 905 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Rks.

D47969 HEALTH DEPARTMENT—CITY OF BALTIMORE D47969

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2647 Harlem Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cinna T. Williams

(a) RESIDENCE. No. 2647 Harlem Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John L. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Cinna Wollath.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Cinna Williams
(Address) 2647 Harlem Ave

15 Filed NOV 11 1920 ROBERT E KRAUTH Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 22 1920, to Nov 10, 1920, that I last saw her alive on Nov 10, 1920, and that death occurred, on the date stated above, at 2 15 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gastro-Enteritis

(duration) yrs. 1 mos. 19 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) M. O'Neill M. D.

11/11. 1920 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. Brooklyn	Nov 12 1920
20 UNDERTAKER	ADDRESS 1422
Mayor G. Flynn	Light St

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

1947970 HEALTH DEPARTMENT—CITY OF BALTIMORE 1947970

CERTIFICATE OF DEATH.

8-091

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 Bennett Place ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Ruth Kuesman

(Residence in Baltimore: No. 913 Bennett Place St.; ....yrs.,....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, March 3, 1920 (Month) (Day) (Year)

7-AGE, ...yrs. 8 mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Peter J. Kuesman

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Blanche P. Hartwell

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter J Kuesman

(Address) 913 Bennett Place

15-

NOV 11 1920 ROBERT B KRAUTER

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 10, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 5 1920, to Nov 10 1920, that I saw her alive on Nov 10 1920, and that death occurred, on the date stated above, at 8-10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Whooping Cough

..... (Duration) about 2 weeks mos. ds.

(Signed) Henry C Ohls M. D.

Nov 10, 1920 (Address) 1203 W. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery. DATE OF BURIAL, Nov 11, 1920.

20-UNDERTAKER Wm J. Hartwell. ADDRESS 2236 W Baltimore St

Important. See instructions on back of certificate. Be properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47971 HEALTH DEPARTMENT—CITY OF BALTIMORE D47971

CERTIFICATE OF DEATH.

109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital WARD) 12

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas R. Scarrell (Scarrell)

(a) RESIDENCE. No. 312 E 20½ St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Minnie Scarrell

6 DATE OF BIRTH (month, day, and year): Nov 9 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chef Cook

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Florence Va

PARENTS

10 NAME OF FATHER: Miles Scarrell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Hannah Yates

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs Minnie Scarrell
(Address): 312 E 20½ St

15 Filed ....., 19 .....

ROBERT J. [illegible] Registrar

NOV 11 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/9/20 19

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1920, to Nov 9, 1920, that I last saw h[illegible] alive on Nov 8, 1920, and that death occurred, on the date stated above, at 12:25 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Complicated by Nephritis

(duration) 2 yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? Yes Date of Nov 1 1920

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo T Hall, M. D.

, 19 (Address) 1626 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Clay Bank Va	Nov 12 1920
20 UNDERTAKER	ADDRESS
Mrs Robt A Elliott	Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047972 HEALTH DEPARTMENT—CITY OF BALTIMORE 047972

100

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2231 Gram Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Nicholas Hoffman

(a) RESIDENCE. No. 2231 Gram Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 25 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none .000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Nicholas Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Celia Edna Bankard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant George Nicholas Hoffman

(Address) 2231 Gram Ave

15 Filed NOV 11 1920 ROBERT B. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1920, to Nov 10, 1920, that I last saw h[illegible] alive on Nov 10, 1920, and that death occurred, on the date stated above, at 6.45 P.m.

The CAUSE OF DEATH* was as follows:

Tonsilitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Edema Lungs.

(duration) ds. mos. 2 hrs

18 Where was disease contracted if not at place of death? 2231 Gram ave

Did an operation precede death? No Date of none

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas A Fetterhoff, M. D.

(Address) 1807 W North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park.	Nov 13 19

20 UNDERTAKER George Smith

ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

426 - Dup. 7-5-00

Spec.—8-24-14—M. & T.—2000 Blks.

1047973

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047973

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bon Secours Hospital

CITY OF BALTIMORE: (No. Fayette & Eutaw St. 27 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Albert Winchester

(Residence in Baltimore: No. Buford Manor Roland Ave St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH, June (Month) 10 (Day) 1859 (Year)

7-AGE, 61 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). 000

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. James Ray Hosmer

11-BIRTHPLACE OF FATHER (State or Country). New York

12-MAIDEN NAME OF MOTHER. Mrs. Albert

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bon Secours Hosp.

(Address) Fayette Eutaw St.

15- NOV 11 1920 ROBERT B KRAUTER

Filed....., 191... 01848 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 10 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 14 1920, to Nov 10 1920; that I saw her alive on Nov. 10 1920, and that death occurred, on the date stated above, at 10 05 A.m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis of Abdomen (Primary)

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

Pneumonia (Duration) yrs. mos. 4 ds.

(Signed) J. Lloyd Johnson M. D.

Nov 10, 1920 (Address) Bon Secours Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Emmanuel Church Playground	Nov 11, 1920
20-UNDERTAKER	ADDRESS
Henry J. Jenkins Sons Co	Mt. Calvert St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047974 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047974

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Ave cor Virginia Ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Theodore Ludwig

(a) RESIDENCE. No. Franklin Ave. cor Virginia Ave. ST. Fairfield WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Caroline Ludwig

6 DATE OF BIRTH (month, day, and year) Sept. 30th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	1	9	

8 OCCUPATION OF DECEASED 006

(a) Trade, profession or particular kind of work: Black-smith

(b) General nature of industry, business, or establishment in which employed (or employer): Himself

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Caroline Ludwig (Address) Franklin Ave. cor. Virginia

15 Filed NOV 11 1920 ROBERT R KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 19 20 to Nov 8, 19 20

that I last saw h alive on Nov 8, 19 20

and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Right Hemiplegia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Certain Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas Bruns, M. D.

Nov 9 1920 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Nov 11 1920
20 UNDERTAKER	ADDRESS
Philip Herrig	2016 Orleans St.

TION is very important. See instructions on back of c ... be properly classified. Exact statement of OCCUPA- ... of certificates. ... on plain terms, so that it may be ... should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

1947975 HEALTH DEPARTMENT—CITY OF BALTIMORE 1947975

49

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2121 E. Monument ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry C. Ruley

(a) RESIDENCE. No. 2121 E. Monument ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2/19

7 AGE — Years: — Months: 11 — Days: 8 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Chas. A. Ruley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Agnes A. Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Chas. A. Ruley

(Address) 2121 E. Monument

15 Filed NOV 11 1920

ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1920, to Nov. 10, 1920.

that I last saw him alive on Nov. 9 1920.

and that death occurred, on the date stated above, at 2 30 A.m.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sy. & Subj. symp.

(Signed) C. E. Rhoads, M. D.

(Address) 1301 N. Chas st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn

DATE OF BURIAL: Nov. 12 1920

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans

Instructions on back of certificates.

Penalty for failure to file certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047976 HEALTH DEPARTMENT—CITY OF BALTIMORE 047976

CERTIFICATE OF DEATH. X 40

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mrs. Hoch ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Frank Adams

(a) RESIDENCE. No. Salyersville, Ky ST.. WARD. Kentucky

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Apr. 4, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Ky.

PARENTS

10 NAME OF FATHER Riley Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky.

12 MAIDEN NAME OF MOTHER Mary Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky.

14 Informant (Address) Thos. S. Adams Salyersville Ken.

15 NOV 11 1920 ROBERT E. LEE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/10 1920

17 I HEREBY CERTIFY, That I attended deceased from 10/31 1920 to 11/10 1920, that I last saw him alive on 11/10 1920, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Abdominal Carcinomatosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 11/5

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lewis D. Rodgers, M. D.

11/13 1920 (Address) Mrs. Hoch

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashland Ken	11/12/20
20 UNDERTAKER	ADDRESS
Eva A Tacky	Fulton Ky Lafayette

TION is very important. See instructions on back of certificates.

...at it may be properly classified. Exact statement of OCCUPA-

...DEATH in plain terms, so that it ... State

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047977

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047977

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1000 N. Carrollton Ave. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Arthur & Lillian Saunders

(a) RESIDENCE. No. 1000 N. Carrollton Ave. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-8 20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Stillborn			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ood

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Arthur Saunders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lillian Hubbard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lillian Saunders
(Address) 1000 N. Carrollton Ave

15 NOV 11 1920 ROBERT B KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1920, to Nov 10, 1920, that I last saw h-- alive on Nov 9, 1920, and that death occurred, on the date stated above, at 12:40, m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death? 1000 Carrollton Ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) O. H. Flowers, M. D.

, 1920 (Address) 712 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL 11/11/20 19

20 UNDERTAKER Samuel W. Chase - son — ADDRESS 1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spmr.—6-9-19—H. P. Co.—1000 Bks.

1047978 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047978

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Clara V. Tillman

(a) RESIDENCE. No. 424 Millington Lane ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ? 137

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jas Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Wahl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co. Md.

14 Informant Wm. W. Tillman (Address) 424 Millington Lane

15 Filed NOV 11 1920 Registrar ROBERT B KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/8 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30 1920, to Nov. 4 1920, that I last saw h alive on Nov. 4 1920, and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis - Chronic

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. 30 min.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Yes Date of 10/15

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thurman B. Rigdon M. D.

11/9 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 12 1920
20 UNDERTAKER	ADDRESS
George L. Schwartz & Bro	[illegible] St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Lyons.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047979 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047979

CERTIFICATE OF DEATH.

37

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST.: 4 WARD)

2-FULL NAME Margaret Mary Lyons

(a) RESIDENCE. No. 19 E. Saratoga ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 2, 20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Thomas Lyons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary McGrath

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant M. Stamps J. Lyons (Address) 19 E Saratoga St

15 Filed NOV 11 1920 19 ROBERT B LEATHER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/11 1920

17 I HEREBY CERTIFY, That I attended deceased from 10/2 1920, to 11/11 1920, that I last saw h alive on 11/11 1920, and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jno A. Rogers M. D.

11/11 1920 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Nov. 12 1920
20 UNDERTAKER Henry Hoch Son	ADDRESS 1301 E Eager

THIS CERTIFICATE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1047980

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047980

CERTIFICATE OF DEATH.

79

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 580 St Mary's ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cinderella Hopkins

(a) RESIDENCE. NO. 580 St Mary ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 4 mos. 17 ds. How long in U. S., if of foreign birth? 15 yrs. 4 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) June 22 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Warrenton Va

12 MAIDEN NAME OF MOTHER Cinderella Duckett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Cinderella Hopkins 580 St Mary St

15 Date received NOV 11 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9th 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct. 18 1920. to Nov 9th 1920.

that I last saw her dead alive on Nov 9th 1920.

and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows: over

Sudden death: Mitral Stenosis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. B. Evans, M. D

19 (Address) Greene & Franklin Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arlington Cemetery	Nov 11 1920
20 UNDERTAKER Mrs Robert F Elliott	ADDRESS 1223 Fairland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47981

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47981

CERTIFICATE OF DEATH.

REGISTERED NO. 48

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 Covington ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Quinn

(a) RESIDENCE. NO. 1819 Covington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Patrick Quinn

6 DATE OF BIRTH (month, day, and year) year. 1843.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	Exact date unknown.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Lawrence O'Brannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Hillard.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Lawrence Quinn

(Address) 1819 Covington

15 NOV 11 1920 ROBERT B KLAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1920, to Nov. 9, 1920, that I last saw h[illegible] alive on Nov 8, 1920, and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ——— if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm J Keaney, M. D.

11-10, 1920 (Address) 638 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Nov. 12 1920

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

47982

HEALTH DEPARTMENT—CITY OF BALTIMORE

47982

CERTIFICATE OF DEATH.

19

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3422 Mt Pleasant Ave ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Schlunderberg

(a) RESIDENCE. No. 3422 Mt Pleasant Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Schlunderberg Jr.

6 DATE OF BIRTH (month, day, and year) May 3 - 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment In which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Larkin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A. McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Conrad Schlunderberg Jr. (Address) 3422 Mt Pleasant Ave

15 NOV 12 1920 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1920

17 I HEREBY CERTIFY, That I attended deceased from September 10, 1920, to Nov 9 -, 1920, that I last saw h.. alive on Nov 9, 1920, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Dis -

(duration) 2 yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Contrac. Failure

(duration) - yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Dr. O'Brien, M. D.

19 (Address) 125 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Nov 12 1920
20 UNDERTAKER H. Sander Sons	ADDRESS 1310 Park Ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

1047983 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047983

Hebrew Asylum 105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Monument Street and

CITY OF BALTIMORE: (No. Rutland Avenue ST.; 6 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hebrew Hospital / Isadore Levin

(Residence in Baltimore: No. 172 Anne st St.; 17 yrs., — mos. 5 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, ..., 1889
(Month) (Day) (Year)

7-AGE, 31 yrs. — mos. — da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Stazky Louis

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Plotkin

(Address) 1012 Granby st

15- NOV 12 1920 ROBERT P. BRAUTER

Filed....., 191.... Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 — 11 —, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11 — 8 — 1920, to 11 — 11 — 1920, that I saw h[illegible] alive on 11 — 11 — 1920, and that death occurred, on the date stated above, at 2 yrs 1 m.

The CAUSE OF DEATH* was as follows:

Pulmonal Ulcer

.....

.....

..... (Duration).....yrs.....mos.....da.

CONTRIBUTORY (Secondary) Hemorrhages from Ulcer

..... (Duration).....yrs.....mos.....da.

(Signed) Benj Tucks M. D.

Nov 11, 1920 (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Washington, D.C.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Hebrew Rosedale	Nov. 12, 1920
20-UNDERTAKER Max Jenson	ADDRESS 1221 E Balto st

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very ... may be properly classified. ... should state ...

Burial Form [illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

47984 HEALTH DEPARTMENT—CITY OF BALTIMORE 47984

CERTIFICATE OF DEATH. 6-91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 Bank St ST.: 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Zamara

(a) RESIDENCE. NO. 1514 Bank ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jan Zamara

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Rozalia Kaltanowna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Zamara
(Address) 1514 Bank

15 Filed NOV 12 1920 ROBERT J. KRAUTER Registrar
Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1920, to Nov. 10, 1920, that I last saw him alive on Nov. 10, 1920, and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) - yrs. - mos. 2 ds.

CONTRIBUTORY (Secondary) -
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) Edward Novak, M. D.

19 (Address) 821 N. Pat. Pk. Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov 12 1920
20 UNDERTAKER	ADDRESS
John A. Weber	1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

47985 HEALTH DEPARTMENT—CITY OF BALTIMORE 167 47985

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. Md. Gen. Hosp. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Regenia Michalska

(Residence in Baltimore: No. 2116 Oak St — St.; 2 yrs. 11 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
female	white	single

6-DATE OF BIRTH, November 17, 1918 (Month) (Day) (Year)

7-AGE, 2 yrs. 11 mos. 10 ds. — If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none (child)
(b) General nature of industry, business, or establishment in which employed (or employer): (child)

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Walter Michalska

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Josepha Reshisaska

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Michalska

(Address) 1928 Forest St.

15- Filed NOV 12 1920 ROBERT A. KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 10, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

third degree burns (accidental) (Children playing with paper & gas stove)

3 hrs. (Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) ....(Duration) ....yrs. ....mos. ....da.

(Signed) J. J. Hennessey M. D. (Coroner)

Nov. 11, 1920 (Address) 2802 Edgewood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 2116 Oak St.

Former or usual residence 2116 Oak St.

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St Marys Evangelical Ref.	Nov 13, 1920

20-UNDERTAKER	ADDRESS
Wendel Hyppel & son	37 Conn Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

47986 HEALTH DEPARTMENT—CITY OF BALTIMORE 47986

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1538 N. Gay St. ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME KAREL Karel Vesely (VESELY)

(a) RESIDENCE. NO. 1538 N Gay St ST., ... WARD. 8

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Vesely (Walthour)

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor 080

(b) General nature of industry, business, or establishment in which employed (or employer) Not employed

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER John Vesely

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Walthour

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Mary Vesely
(Address) 1538 N Gay St

15 Filed NOV 12 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1920, to Nov 10, 1920, that I last saw h[illegible] alive on Nov 10, 1920, and that death occurred, on the date stated above, at 2.00 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Rowark M. D.

(Address) Nov 11th 1920 1801 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 13 1920
20 UNDERTAKER	ADDRESS
Frank Crockler	1406 Bank Lane

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

47987 HEALTH DEPARTMENT—CITY OF BALTIMORE 47987

105

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 N Madeira St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beatrice Chopalecky

(Residence in Baltimore: No. 918 N. Madeira St.: 3 yrs., 10 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Dec (Month) 14 (Day) 1916 (Year)

7-AGE, 3 yrs. 10 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)..... Infant

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Horpa Chopalecky

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Anna Bolanka

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Horpa Chopalecky

(Address) 94 N Madeira St

15- Filed NOV 12 1920, 191.... ROBERT J. KRAUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 9 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 4 1920, to Nov 9 1920, that I saw h[illegible] alive on Nov 9 1920 and that death occurred, on the date stated above, at 9.10 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Auto-intoxication

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) ....yrs. ....mos. 1 ds.

(Signed) W. Brumbaugh M. D.

11-11 1920 (Address) 800 N Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Nov 12 1920

20-UNDERTAKER Frank Brockton — ADDRESS 1906 Eastland

Important. See instructions on back of certificate. ...properly classified. Exact statement of OCCUPATION is very ...PLACES should state ...of that it may be

47988 HEALTH DEPARTMENT--CITY OF BALTIMORE 47988

CERTIFICATE OF DEATH. 159

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 2013 Hoffman St.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Gotbaw

(Residence in Baltimore: No. 2013 Hoffman St.; yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state correctly supplied.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ...(Month) Sept (Day) 1 (Year) ....

7-AGE, 36 yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Artist
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Charles Gotbaw

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Wagner

13-BIRTHPLACE OF MOTHER (State or Country). Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(informant) Charles Gotbaw

(Address) 1906 Ashland Av

15- NOV 12 1920 Filed ...., 191... ROBERT E KRAUTER Registrar.
Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 8 (Day) 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound

.... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Suicide

.... (Duration) ....yrs. ....mos. ....ds.

(Signed) ....M. D. (Coroner.)

....10th 191... (Address) 143 E Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Nov 13, 1920
20-UNDERTAKER	ADDRESS
Frank Evans	1906 Ashland

47989

HEALTH DEPARTMENT—CITY OF BALTIMORE

47989

CERTIFICATE OF DEATH.

X 182

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2013 Hoffman St. 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Otilie Kastban

(Residence in Baltimore: No. 2013 Hoffman.

St.; yrs., 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Unknown (Month) ..... (Day) 1 (Year)

7-AGE, 19 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Eichler

(Address) 1916 Ashland Ave

15- NOV 12 1920 191... ROBERT A KRAUTER Registrar.

Burial permit issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 8, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot Wounds.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Homicide

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Louis Radcliffe M. D.
(Coroner.)

Nov 9, 191... (Address) 1436 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Oak Hill	Nov 13, 1920
20-UNDERTAKER Frank Enoch Son	ADDRESS, 1916 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

Selma Snead.

D47990

HEALTH DEPARTMENT—CITY OF BALTIMORE

D47990

CERTIFICATE OF DEATH.

122

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO. C

CITY OF BALTIMORE: (No. Monument 11 ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Selma Snead

(Residence in Baltimore: No. 2130 Brookfield ave St.: 72 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov 27 / 47, 1 (Month) (Day) (Year)

7-AGE, 72 yrs. 11 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Edward Snead

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Gertrude Hale

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C K Lukas

(Address) 2130 Brookfield ave,

15- NOV 12 1920 Filed ....., 191.... ROBERT E. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 11, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11-3-20 191, to 11-11-1920, that I saw her alive on 11-11-1920, and that death occurred, on the date stated above, at 4 20 a.m.

The CAUSE OF DEATH* was as follows:

Vesical Dilatation

Chronic Cystitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. 5 ds.

(Signed) Charles S. Levy M. D.

11-11-, 1920 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park. DATE OF BURIAL, Nov 13, 1920

20-UNDERTAKER W J Lecknur Sons ADDRESS North Penna ave

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47991 HEALTH DEPARTMENT—CITY OF BALTIMORE D 47991

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1225 Mosher ST. 16 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Ann Powell

(a) RESIDENCE. No. 1225 N Mosher ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas B. Powell

6 DATE OF BIRTH (month, day, and year): June 13 1846

7 AGE: Years 74 Months 4 Days 28 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Staunton Va

PARENTS

10 NAME OF FATHER: Alexander McClung

11 BIRTHPLACE OF FATHER (city or town) (State or country): Staunton Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Stephen D Powell

(Address) 1225 Mosher St

15 Filed NOV 12 1920

ROBERT E KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 27 1920, to Nov 11 1920, that I last saw her alive on Nov 10 1920, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pericarditis

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Geo Abbott M. D.

11/11 1920 Address) 708 Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westernport Md

DATE OF BURIAL: Nov 12

20 UNDERTAKER: H J Pentecost

ADDRESS: Cumberland Md

THE CAUSE OF DEATH is plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

047992 HEALTH DEPARTMENT—CITY OF BALTIMORE 047992

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 5 WARD) 142

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sam Jones

(a) RESIDENCE. No. 617 Central Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER William B. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rosalla Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records, (Address) New City Hospital.

15 FILED NOV 12 1920 ROBERT A KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 10, 1920

17 I HEREBY CERTIFY, That I attended deceased from November 6, 1920 to November 10, 1920, that I last saw him alive on November 10, 1920, and that death occurred, on the date stated above, at 2:00 P. m.

The CAUSE OF DEATH* was as follows:

Gangrene of foot. (Traumatic) unknown. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicaemia & Cachexia unknown. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? not as yet.

What test confirmed diagnosis?

(Signed) F. A Holden, M. D.

11/10/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Nov 13 1920
20 UNDERTAKER	ADDRESS
Chas G Bailey	142 Lanvale St

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D47993 HEALTH DEPARTMENT—CITY OF BALTIMORE D47993

137

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Rutland Ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Bagley Morgan

(a) RESIDENCE. NO. 1118 Rutland Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19-10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Morgan

6 DATE OF BIRTH (month, day, and year) Oct 9-1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
19				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Bagley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Nannie Booker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) James Bagley 1767 Carlisle Pl.

15 Filed NOV 12 1920 ROBERT F. LEATHER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-9- 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 3 1920. to Nov 9 1920. that I last saw her alive on Nov 9 1920. and that death occurred, on the date stated above, at 7.30 P.m.

The CAUSE OF DEATH* was as follows:

Puerperal septicemia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas M. D.

11-10 1920 (Address) 822 N Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Nov 12th 1920

20 UNDERTAKER	ADDRESS
Chas G. Bailey	1421 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

1047994

HEALTH DEPARTMENT—CITY OF BALTIMORE

1047994

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 N. Broadway St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham M. Rosenblatt

(Residence in Baltimore: No. 1034 N. Broadway St.; 13 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, June (Month) 27 (Day), 1894 (Year)

7-AGE, 26 yrs. 4 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)..... 066

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Jacob Rosenblatt

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER, Mollie Philipsta

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Baltimore

15- NOV 12 1920 ROBERT B KRAUTER

Filed....., 191.... Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 11 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 20 1920, to Nov 11 1920, that I saw him alive on Nov 7 1920, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Laryngitis

(Duration) 1 yrs. mos. ds.

(Signed) Bernard M. Bernstein M. D.

Nov 11, 1920 (Address) 3447 Pk Hgts Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Pikesville Burying Assn

DATE OF BURIAL, Nov 13, 1920

20-UNDERTAKER Jos J. Lewis

ADDRESS 1411 East Balto St.

IMPORTANT: PHYSICIANS should state clearly and fully the facts, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

647995 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 172 647995

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Graus — REGISTERED NO. C

CITY OF BALTIMORE: (No. 517 Ravenswood Av ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine C. Morgan

(Residence in Baltimore: No. 517 Ravenswood Ave St.; 70 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	widow

6-DATE OF BIRTH, Oct 20, 1850 (Month) (Day) (Year)

7-AGE, 70 yrs. mos. da. — If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Unemployed
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm L. Jackson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Leah Chalk

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah A. Morgan

(Address) 517 Ravenswood Ave

15- Filed NOV 12 1920, 191... ROBERT B. KRAUTER Registrar. Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 9th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 1920, to Nov. 9th 1920, that I saw her alive on Nov. 3rd 1920, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

1a Chr. Myocarditis (several years)

* Partial Hemiplegia

(Duration) yrs. mos. 13 da.

CONTRIBUTORY (Secondary) Injury from fall

(Duration) yrs. mos. da.

(Signed) J W Keown M. D.

Nov 11, 191... (Address) 1938 Lindenture

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. — In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Johns Cem	Nov 12, 1920

20-UNDERTAKER	ADDRESS
Chas E. Pearce & Son	847 Madison Ave

(Over)

important. See instructions on back of certificate.

Spcy.—6-9-19—H. P. Co.—1000 Blks.

47996 HEALTH DEPARTMENT—CITY OF BALTIMORE 47996

CERTIFICATE OF DEATH.

104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 N. Bond ST.; 7 WARD)

2-FULL NAME Thomas M. Harrington

(a) RESIDENCE. No. 906 N. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Sing'l.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Milton Harrington

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Catherine McCabe

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs. Catherine Harrington
(Address) 906 N. Bond St

15 Filed NOV 12 1920 ROBERT E. LAZARUS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 30 1920 to Nov 11th 1920, that I last saw h[illegible] alive on Nov 11th 1920 and that death occurred, on the date stated above, at 10 20 P m.

The CAUSE OF DEATH* was as follows:

Carbo Cutaneous Gangrene

(duration) yrs. one mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

[illegible] 1920 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Nov. 13 1920
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

1047997 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047997

CERTIFICATE OF DEATH. 40

1-PLACE OF DEATH 910 St Paul St REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... St.; 11 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eleanor Fulford Torrance Conner

(Residence in Baltimore: No. 910 St. Paul Street St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	married

6-DATE OF BIRTH, May (Month) 18 (Day), 1839 (Year)

7-AGE, 81 yrs. 6 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none 037
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, George Torrance

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Eleanor Fulford

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James A. Conner

(Address) 910 St Paul Street

15- Filed NOV 12 1920 191..... ROBERT E KRAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 9th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 10th 1920, to Nov. 9th 1920, that I saw her alive on Nov. 8th 1920, and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) ..... yrs. 9 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) William J. Iressick M. D.

Nov. 11th 1920 (Address) 1700 Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cem	11-2..., 1920
20-UNDERTAKER Henry W. Jenkins Son	ADDRESS Orchard & McCulloh

important. See instructions on back of certificate.

Spec.—6-9-19—B. P. Co.—1000 Rks.

1047998 HEALTH DEPARTMENT—CITY OF BALTIMORE 1047998

CERTIFICATE OF DEATH. 120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cherry Hill nr Westport Md St.: 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H ans

(a) RESIDENCE. No. Cherry Hill Westport St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 17 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John H ans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eliz Bickel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wm F Lapp
(Address): Cherry Hill

15 NOV 12 1920 ROBERT F. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 20

17 I HEREBY CERTIFY, That I attended deceased from Nov 5 1920 to Nov 9 1920

that I last saw h alive on Nov. 8 1920

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A Ethan Franks, M. D.

Nov 10, 1920 (Address) 1412 Eye & Ear

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem "

DATE OF BURIAL: 11-12 1920

20 UNDERTAKER: Henry W. Jenkins Sons Co

ADDRESS: Orchard & McCulloh

CAUSE OF DEATH in plain terms, so that it should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D47999 HEALTH DEPARTMENT—CITY OF BALTIMORE D47999

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C 104

CITY OF BALTIMORE: (No. 1402 McCulloh ST.; 14 WARD)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Juanita Goodman

(Residence in Baltimore: No. 1402 McCulloh St.; ..... yrs., mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: Colored | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6-DATE OF BIRTH, Nov 4 (Month) (Day), 1920 (Year)

7-AGE, ... yrs. mos. 6 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: ✓
(b) General nature of industry, business, or establishment in which employed (or employer): ppp

9-BIRTHPLACE, (State or Country), 1402 McCulloh St

PARENTS.

10-NAME OF FATHER, John Goodman

11-BIRTHPLACE OF FATHER (State or Country), Va "

12-MAIDEN NAME OF MOTHER Melinda Shuter

13-BIRTHPLACE OF MOTHER (State or Country), Va "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Goodman

(Address) 1402 McCulloh St

Filed NOV 12 1920, 191.... ROBERT E LEAUTER

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 10th (Month) (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 7th 1920, to Nov. 10th 1920, that I saw him alive on Nov. 10th 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. E. Ellis M. D.

11/12, 1920 (Address) 914 Mad. Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn | DATE OF BURIAL, 11 14, 1920

20-UNDERTAKER Samuel T Kinsley | ADDRESS 578 Mid

IMPORTANT: Physicians will please write plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48000 84 D48000

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH Roland Park

CITY OF BALTIMORE: (No. 201 Goodwood Gardens ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sullivan Pitts

(a) RESIDENCE. NO. 201 Goodwood Gardens ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or Divorced (write the word)
Male	white	Child

5a If ~~married, widowed,~~ or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 30-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) md.

PARENTS

10 NAME OF FATHER Dilghman Pitts

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) md.

12 MAIDEN NAME OF MOTHER Dorothea Paine

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) maryland

14 Informant Dilghman Pitts
(Address) Roland Park

15 NOV 12 1920 BOREAU OF STATISTICS Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 10th, 1920, to Nov 11th, 1920, that I last saw h~~e~~r alive on Nov 10th, 1920, and that death occurred, on the date stated above, at 1.30 ~~P.~~ M.

The CAUSE OF DEATH* was as follows:

Status Lymphaticus; Resp. Pneumonia

Thymus Death

(4 hours illness)

(duration) yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary) Respiratory Stridor Thymus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes ~~Laryngoscopy~~ Yes

What test confirmed diagnosis?

(Signed) C B Garnett Jr, M. D.

, 19 (Address) 24 N Bidd[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	11-11 1920

20 UNDERTAKER Henry J Enskins Son Co ADDRESS 1[illegible] Eighth Ave Orchard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA. is very important. See instructions on back of certificates.

Spec.—8-24 14—M. & T.—2000 Blks.

Giller

1048001 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048001

CERTIFICATE OF DEATH.

14 X 50

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Louisa Giller

(Residence in Baltimore: No. Womans Hospital St.; ~~57~~ yrs., mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, June (Month) 18 (Day), 1864 (Year)

7-AGE,	If LESS than 1 day,
56 yrs. 4 mos. 23 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, William Benders

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret Leckhauser

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret L. Giller

(Address) 1 Millers P.O. Carroll

15- Filed NOV 12 1920 191... ROBERT J KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 11 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1920, to Nov. 11, 1920, that I saw h-er alive on Nov. 11, 1920, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(Duration) 10 minutes

CONTRIBUTORY (Secondary) Diabetes & Gangrene-Foot.

(Duration) 5 yrs. mos. ds.

(Signed) Frank Wentworth Stone M. D.

Nov. 11, 1920 (Address) Womans Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. 25 ds. In the State 5 yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence Keller Station, Carroll Co., Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Nov. 13, 1920
20-UNDERTAKER Henry W. Jenkins Sons	ADDRESS Mt. Washington Baltimore

Important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

1048002 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048002

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Lubinski

(a) RESIDENCE. No. 2211 Canary Court ST.,..... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tillie Lubinski

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dock builder

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Casmer Lubinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Augusta Annowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

11 Informant Hospital Records

(Address) M. C. H.

NOV 12 1920 ROBERT J. FRAZIER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1920, to Nov. 10, 1920, that I last saw h. im alive on Nov. 9, 1920, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Ulceration of colon, sigmoid & rectum with hemorrhage (Unkn

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum.

(Signed) M. J. Rigney, M. D.

11-10-20. (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Nov 13 1920
20 UNDERTAKER	ADDRESS
Stephen J. Fialkowski	1000 S. Kenwood

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease should be stated EXACTLY. PHYSICIANS should fill out this CERTIFICATE

Spec.—8-24-14—M. & T.—2000 Bks.

2048003

HEALTH DEPARTMENT—CITY OF BALTIMORE

2048003

CERTIFICATE OF DEATH.

5 104

REGISTERED No. C.....

1-PLACE OF DEATH James

CITY OF BALTIMORE: (No. 1706 Allen ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jos R Fulton

(Residence in Baltimore: No. 1706 Allen St.: 1 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Child

6-DATE OF BIRTH, Jan 15 (Month) (Day) 1918 (Year)

7-AGE, 1 yrs. 10 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None 000
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER, Watson Fulton

11-BIRTHPLACE OF FATHER (State or Country). S. Carolina

12-MAIDEN NAME OF MOTHER Mary Fulton

13-BIRTHPLACE OF MOTHER (State or Country). S. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Watson Fulton

(Address) 1406 Orleans St.

15-

NOV 12 1920 ROBERT B BRAUTER

(Date) ..... 191... Burial Permit (Registrar.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 11, 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6 1920, to Nov 11 1920, that I saw h... alive on Nov 11 1920, and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as followa:

..... Lobar Pneumonia .....

..... (Duration) ..... yrs. ..... mos. 6 ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Albany Co.,	Nov 13, 1920

20-UNDERTAKER	ADDRESS
Harry A Woodcock	1725 Carlton St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D48004

HEALTH DEPARTMENT—CITY OF BALTIMORE

64 D 48004

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 428 Hurst st. St.; 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H. Cooper Sr.

(Residence in Baltimore: No. 428 Hurst st. St.; 63 yrs., 24 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widowed

6-DATE OF BIRTH: Oct (Month) 10 (Day), 1857 (Year)

7-AGE: 63 yrs. 2 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tool grinder
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country): md

PARENTS.

10-NAME OF FATHER: George Cooper.

11-BIRTHPLACE OF FATHER (State or Country): md

12-MAIDEN NAME OF MOTHER: Julia Cook

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George H. Cooper Jr.

(Address) 428 Hurst st

15-

Filed NOV 12 1920, 191.... ROBERT P. ARAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 10 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 4 1920, to Nov 10 1920, that I saw h~~e~~d alive on Nov 10 1920, and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) no yrs. 10 mos. 6 ds.

CONTRIBUTORY (Secondary) Myocarditis Primary

(Duration) no yrs. no mos. 6 ds.

(Signed) Raymond Glenn M. D.

Nov 11, 1920 (Address) 2 Belmont

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Nov 15 20 191....

20-UNDERTAKER F. D. Shipley — ADDRESS 2236 Eastern Ave

Cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks. 50 84 10'e Steinbock

D48005 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48005

CERTIFICATE OF DEATH.

REGISTERED NO. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 W Fortune ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Maggie Steinbach

(a) RESIDENCE. NO. 13 W Fortune ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 7 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Steinbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Miss Walper

(Address) 513 Fremont St.

15 Filed NOV 12 1920, 19 ROBERT B. BAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1920

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1920, to Nov 9, 1920, that I last saw h[illegible] alive on Nov 8, 1920, and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia
Cerebral Hemorrhage
Disease
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physicians Certificate

(Signed) Henry Gross, M. D.

11/11/1920 (Address) 508 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 12 1920
20 UNDERTAKER	ADDRESS
Wm J. Eckhardt	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D48006

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48006

CERTIFICATE OF DEATH.

X/20

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 William St. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Sundle

(a) RESIDENCE. No. Annapolis Md St., Ward. Annapolis Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edw J Sundle

6 DATE OF BIRTH (month, day, and year) Oct 13 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 100

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Md

PARENTS

10 NAME OF FATHER Levin Dacon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margaret A. Burke

(Address) 1222 William St.

15 NOV 12 1920 ROBERT N. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 19 20, to Nov 9, 19 20,

that I last saw her alive on Nov 9, 19 20,

and that death occurred, on the date stated above, at 10 0 m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Chronic myocarditis unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Annapolis Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urin depos + physician

(Signed) Wm Belfield, M. D.

11/11. 1920 (Address) 1319 Eights St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Nov 12 1920

20 UNDERTAKER John F Taylor ADDRESS 1318 Eight St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Nos. 1 and 2. Entry of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D48007 HEALTH DEPARTMENT—CITY OF BALTIMORE D48007

CERTIFICATE OF DEATH.

155

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Md. Gen. Hosp., ST. 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary E. Dunn

(Residence in Baltimore: No. 604 St. Paul St. St.; yrs., 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	married

6-DATE OF BIRTH, October ?, 1886
(Month) (Day) (Year)

7-AGE, 34 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Missouri

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. B. Dunn

(Address) 604 St. Paul St.

15- Filed NOV 12 1920 191.. ROBERT B BRUTER Burial Permit Issued Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 9, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest~~ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide (Heroin)

3 hrs.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Nov. 9, 1920 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 604 St. Paul St.

Former or usual residence 604 St. Paul St.

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Druid Ridge	Nov 12, 1920
20-UNDERTAKER Jos B Cook	ADDRESS 1003 Balto St

Changed 1/18/1921 See affidavit. (Over)

Spec.—6-9-19—H. P. C.—1000 Bks.

1048008

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048008

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Clara E. H. Constantine

CITY OF BALTIMORE: (No. 4749 Park Heights Ave. WARD 27)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Elizabeth~~ H. Constantine

(a) RESIDENCE. No. 4749 Park Heights St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
~~Female~~	White	Married

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Custodulo Constantine

6 DATE OF BIRTH (month, day, and year) July 1, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Chas. A. Hadel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ella K. Kemp

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Wm. K. Hadel
(Address) 4617 Pimlico Road

15 Filed NOV 12 1920 ROBERT B. LEAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1920, to Nov 11, 1920,
that I last saw h~~e~~r alive on Nov 10, 1920,
and that death occurred, on the date stated above, at 2 A m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Int. Nephritis

(duration) ....yrs. 6 mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John D. Bubert M. D.

Nov 11, 1920 (Address) 4754 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Nov. 13 1920
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

I hereby state that I believe Elizabeth H. Constantine, whose death I certified to have occurred on November 11th. 1920, to be the same person as Clara C. H. Constantine.

John D. Bubert M.D. (Seal)

STATE OF MARYLAND:
CITY OF BALTIMORE:

TO WIT:

I HEREBY CERTIFY: That on this 17th day of January in the year nineteen hundred and twenty-one, before me, the subscriber, a Notary Public of the State of Maryland, in and for the City of Baltimore aforesaid, personally appeared John D. Bubert M.D. and acknowledged the aforegoing statement to be his statement, and to be true to the best of his knowledge and belief.

Witness my hand and Notarial seal.

Joseph N. Ramos
Notary Public.

Spec.—6-9-19—H. P. Co.—1000 Bks.

L048009

HEALTH DEPARTMENT—CITY OF BALTIMORE

L048009

CERTIFICATE OF DEATH.

186

1-PLACE OF DEATH

CITY OF BALTIMORE, No. St Joseph's Hospital ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Forni

(a) RESIDENCE. No. 304 Brighton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) August 19, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Arthur G. Forni

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice McDonnell

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant John J. McDonnell
(Address) 2525 Rayner Avenue

15 Filed NOV 12 1920 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 19 20

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 19 20, to Nov 11, 19 20,
that I last saw him alive on Nov 11, 19 20,
and that death occurred, on the date stated above, at 10.10a m.
The CAUSE OF DEATH* was as follows:
Pulmonary Odema

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pneumonia Lobular both lungs
(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Nov 10/20

Was there an autopsy? Yes

What test confirmed diagnosis? Examination of sputum

(Signed) Charles L Cook, M. D.

Nov 11, 1920 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	11/13 1920
20 UNDERTAKER Henry W. Mears & Son 805	ADDRESS N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. Every item should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

D. 48010

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48010

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 Ramsay ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Selmer Coaptin

(a) RESIDENCE. NO. 720 Ramsay ST., 21 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 11-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 7 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James M. Coaptin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Daisy Bennett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs J. M. Coaptin

(Address) 720 Ramsay St.

15 Filed ... 19...

Robert P. Harrison,
Registrar

Burial Permit Clerk.

NOV 12 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1920, to Nov 12, 1920, that I last saw him alive on Nov 11, 1920, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Premature (7 months)

(duration) ... yrs. ... mos. ½ ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Wiley Straig, M. D.

1920 (Address) 719 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 15 1920
20 UNDERTAKER	ADDRESS
John J. Fells	1200 W. Lombard

CAUSE OF DEATH should be stated EXACTLY, PHYSICIANS should state it may be properly classified. See instructions on back of certificates.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48011

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48011

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4801 Crowson Ave ST.) 27 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Reid Heath

(a) RESIDENCE. NO. 4801 Crowson Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1st 1848

7 AGE — Years: 72 — Months: 10. — Days: 9 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Duties

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: James Reid

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Suzanna Gracey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Benjamin H. Heath

(Address) 4801 Crowson Ave

15 Filed NOV 12 1920 19

Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 3d, 1919, to Nov 10, 1920, that I last saw her alive on Nov 10, 1920, and that death occurred, on the date stated above, at 7 10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion + Toxaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Found Bacilli in Sputum

(Signed) Clara Lewis, M. D.

Nov 10 1920 (Address) 4756 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Nov. 13. 1920

20 UNDERTAKER	ADDRESS
Mr. & Mrs. John W. Teufel	801 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48012

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48012

CERTIFICATE OF DEATH.

H5

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #3 Ruckert Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Nilson

(a) RESIDENCE. No. #3 Ruckert Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 31, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales-Lady 066

(b) General nature of industry, business, or establishment in which employed (or employer) Hutzler & Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. W. Nilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Anna E. Langemann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. J. L. Rubel
(Address) 3 Ruckert Ave

15 Filed ..... Robert P. Harrison,
Registrar
Burial Permit Clerk.

NOV 12 1920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 19 20

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 19 20 to Nov 10, 19 20, that I last saw her alive on Nov 10, 19 20, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Pelvic Carcinoma
(Organ involved)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion
to Carcinoma (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Clara Downing, M. D.

Nov 11 19 20 (Address) 1706 Hoffman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov. 13, 1920
20 UNDERTAKER	ADDRESS
E. D. Fanning & Son	1938 E. Lafayette ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of the PA-TION is very important. See instructions on back of certificates.

D.48013

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48013

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79-091

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca VanDyke

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed ..., 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 8 1920

17 I HEREBY CERTIFY, That I attended deceased from November 4, 1920 to November 8, 1920.
that I last saw her alive on November 7, 1920.
and that death occurred, on the date stated above, at 5:30 A. m.
The CAUSE OF DEATH* was as follows:

Myiocardial insuff-
iciency
(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneum-
onia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Not as yet

What test confirmed diagnosis? Phy. exam.

(Signed) J. A. Holden, M. D.

11/8/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	Nov 12 1920
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of certificates.
TION is very important. See instructions on back of

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48014

D. 48014

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1308 N. Vincent ST.: 15 WARD)

2-FULL NAME Sallie Brown

(a) RESIDENCE. No. 1308 N. Vincent ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

be stated EXACTLY. AGE should be s
CAUSE OF DEATH in plain terms, so that it may be pr
TION is very important. See instructions on back of cer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Boce Brown

6 DATE OF BIRTH (month, day, and year) Mar 1 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Day Work

9 BIRTHPLACE (city or town) (State or country) a a Co Md

PARENTS

10 NAME OF FATHER William Branford

11 BIRTHPLACE OF FATHER (city or town) (State or country) A A Co Md

12 MAIDEN NAME OF MOTHER Delia Queen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chas Co Md

14 Informant Mary Jones
(Address) 213 N Chatsworth St

15. Filed NOV ... 1920. Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1920

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1920, to Nov 10, 1920, that I last saw h[illegible] alive on Nov 9, 1920, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? Urinary findings

(Signed) Wm Fahey, M. D.

11 . 1920 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Nov 13 1920

20 UNDERTAKER Edw. Ringgold ADDRESS 1463 Carey St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48015 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48015

CERTIFICATE OF DEATH. 64

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 S. Charles ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Harris

(a) RESIDENCE. NO. 622 S. Charles ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 11, 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary L. Gray
(Address) 415 Plum alley

15 Filed NOV 13 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1920, to Nov 10, 1920, that I last saw h— alive on Nov 10, 1920, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows: Paralysis Cerebral Hemorrhage

(duration) — yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? 622 S. Charles Street

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. W. Flowers M. D.

Nov 11, 1920 (Address) 712 S. Sharp Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Nov. 13 1920
20 UNDERTAKER	ADDRESS
N. L. Brown & Son	108 W. Monty

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D. 48016 HEALTH DEPARTMENT--CITY OF BALTIMORE D. 48016

CERTIFICATE OF DEATH

43

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 702 W. North ave ~~St.~~ 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Margaret A. Burns

(Residence in Baltimore: No. 702 W. North ave ~~St.~~ 45 yrs. 0 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Oct. (Month) 26 (Day), 1875 (Year)

7 AGE: 45 yrs. 0 mos. 16 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9 BIRTHPLACE (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Felix A. Savin

11 BIRTHPLACE OF FATHER (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mary E. Anderson

13 BIRTHPLACE OF MOTHER (State or country): Baltimore, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Delia A. Anderson

(Address) 702 W. North ave

15. Filed Nov 13 1920, 191

Robert P. Harrison,
Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. (Month) 12 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16, 1920, to Nov. 11, 1920, that I saw her alive on Nov. 11, 1920, and that death occurred, on the date stated above, at 4 a.m.
The CAUSE OF DEATH* was as follows:

Cancer of Lungs

(Duration) ..... yrs. 5 mos. ..... ds

Contributory (SECONDARY) Cancer of Left Breast

(Duration) about 1 yrs. ..... mos. ..... ds

(Signed) Wm. M. Lamebaker M. D.

Nov. 12, 1920 (Address) 620 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: Nov 14, 1920

20 UNDERTAKER: John C. Mitchell — ADDRESS: 130 N Eutaw

Very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48017 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.

CERTIFICATE OF DEATH. 120

REGISTER

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 Linden Ave. ST.: 11 WARD)

2-FULL NAME Susan Kent Thurley

(a) RESIDENCE. NO. 1216 Linden Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dress-maker for self

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer

9 BIRTHPLACE (city or town) Greensboro
(State or country) N.C.

PARENTS

10 NAME OF FATHER Samuel Thurley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Emily Kent

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant
(Address) Miss Alice Thurley 1216 Linden Ave.

Filed [illegible] 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12, 1920

17 I HEREBY CERTIFY, That I attended deceased from June 2 - , 1920, to Nov 10 , 1920, that I last saw her alive on Nov 9½ , 1920, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis-

(duration) Many yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemia — (duration) — yrs. — mos. 5½ ds.

18 Where was disease contracted if not at place of death? Unknown —

Did an operation precede death? No — Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Urinary Exam —

(Signed) Chas Lerman — M. D.

Nov 10 1920 (Address) 1327 Park Ave. - Balto —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Nov. 13" 20

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 N. Bal... Stree...

so that it may be properly ... actions on back of certificates.

Missing

#D 48018

&

D 48019

Missing

#D 48018

&

D 48019

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

D.48020 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48020

CERTIFICATE OF DEATH.

175-001

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) University Hospital ST.: 11 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 1S.)

2-FULL NAME Charlotte C. H. Smith

(Residence in Baltimore: No. 18 E. Madison st. St.; yrs., 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Oct (Month) 2 (Day), 1853 (Year)

7-AGE, 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Geo. H. Williams

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elenor Addison

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. Darrah

(Address) Ruby

15-

Filed...../...../....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ~~Oct~~ Nov. (Month) 11 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.....(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(Duration).....

CONTRIBUTORY (Secondary) Accidental Fall

(Duration)

(Signed).....

11-12, 1924 (Address)

*State the DISEASE CAUSING DEATH, or, if from violence, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS ONLY.)

At place of death.....yrs.....

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF OCCURRENCE Ground

20-

(Signature and Title) Geo. F. Garrison, M.D.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48021

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48021

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 W. 26 St ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie L Blouse

(a) RESIDENCE. NO. 427 W. 26 St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 4 1920

7 AGE — Years — Months — 8 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work POD

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ballo City Md

PARENTS

10 NAME OF FATHER Jesse Blouse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Augusta L Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jesse Blouse (Address) 427 W. 26 St

15 Filed NOV 13 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1920, to Nov 12, 1920, that I last saw her alive on Nov 12, 1920, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth (8 mo)
Inanition.

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Geo Woolf M.D., M. D.

11/12 1920 Address) 2020 N. Charles St,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St Marys Hampden Nov 13 1920

20 UNDERTAKER — ADDRESS

Paul E Ehenoweth 3417 Edmondson ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48022

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48022

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 930 Woodland Ave. Ward 27)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn E Smith

(a) RESIDENCE. No. 930 Woodland Ave. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 5 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER H Smith

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Elizbeth Sterner

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Harry Smith
(Address) 930 Woodland Ave

15 Filed NOV 13 1920 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1920, to Nov 12, 1920, that I last saw her alive on Nov 12, 1920, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth (8 mo)
Inanition

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Prowdon H Bell, M. D.

11/12 1920 Address) 2020 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Nov 13 1920

20 UNDERTAKER Chenowith Son ADDRESS Chestertown

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Examination of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 48023 ✓ D. 48023

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 640 Mt. Ave ST.; 25 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent F. Johnson

(Residence in Baltimore: No. 640 Mt. Ave St.; ... yrs., ... mos. ... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	white	

6-DATE OF BIRTH, 18 June, 1919.
(Month) (Day) (Year)

7-AGE, 1 yrs. 9 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work — 000
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John R Johnson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Florence Ward

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A. Johnson

(Address) Brooklyn

15-

Filed ..... 191....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

NOV 13 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 11, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 7 1920, to Nov 11 1920, that I saw h— alive on Nov 11 1920, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

Acute

(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... da.

(Signed) Chas. F. Brooks M. D.

Nov. 11, 1920. (Address) Brooklyn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross	Nov. 13, 1920
20-UNDERTAKER J. F. Denny JOHN F. DENNY	ADDRESS Bells

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D.48024 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48024

CERTIFICATE OF DEATH. 104

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2016 Keyser St., 8 Ward) REGISTERED No. C

2-FULL NAME Mrs. Kelley. Boyque

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2016 Keyser. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH. July 18, 1920
3 months (Month) 3 (Day) (Year)

7-AGE. yrs. 3 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE. (State or Country). born in Baltimore City

PARENTS.

10-NAME OF FATHER. Andrew Broyque

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER Julia Marshall

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Broyque

(Address) 2016 Keyser St

15- Robert P. Harrison,

Filed NOV 13 1920, 191. Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot Contusion

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) G. C. Glades M. D.
11/13/20 (Coroner.) (Address) 1432 N. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL
Laurel Cemetery	November 15, 19

20-UNDERTAKER Mrs Robert J Elliott ADDRESS 172 Ashland

D.48025 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48025

CERTIFICATE OF DEATH.

175-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 15 WARD)

(If death occurred in hospital or Institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Jacobs

(Residence in Baltimore: No. 3207 Hokins Road) St.; yrs., mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ..., 1913.
(Month) (Day) (Year)

7-AGE, 7 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Chas Jacobs

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C C Kennard

(Address) 113 W Lafayette St

15- Robert P. Harrison,

Filed NOV 23 1920, 191.....
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... ~~(Inquest, autopsy or~~ inquiry thereon and from the evidence obtained by said ..... ~~(Inquest, au~~ ..... find that said deceased came to ~~(topsy or inquiry.)~~ death on the day stated above.

The CAUSE OF DEATH* was as follows: From Hemorrage Shock due to being run over by Auto truck having both legs crushed

..... (Duration) ..... yrs. ..... mos. 4 hrs ds.

CONTRIBUTORY (Secondary) accidentaly as above

..... (Duration) ..... yrs. ..... mos. 4 hrs ds.

(Signed) H B Jonnard M. D.
(Coroner.)

11-12, 1920 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Nov 15 1920
20-UNDERTAKER	ADDRESS
L F Wolke	723 W Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.48026

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.48026

CERTIFICATE OF DEATH.

X 64

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1810 N. Register ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ceska

(a) RESIDENCE. NO. 1810 N. Register ST., WARD. Preston Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Ceska

6 DATE OF BIRTH (month, day, and year) March 11, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Frank Ceska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Anna Petran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant (Address) Frank Ceska Preston, Md

15 Filed ....., 19.....

Robert P. Harrison, Registrar

NOV 13 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7 1920, to Nov 11 1920, that I last saw him alive on Nov 11 1920, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Kramer M. D.

Nov 13 1920 (Address) 501 N Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Nov 15 1920

20 UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 Eager

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48027 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48027

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 N Bruce ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Henry Parker

(a) RESIDENCE. NO. 318 N Bruce ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 12 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter in D70

(b) General nature of industry, business, or establishment in which employed (or employer) retail Grocery

(c) Name of employer Bailey, "Grocer",

9 BIRTHPLACE (city or town) Baltimore
(State or country) md,

PARENTS

10 NAME OF FATHER James Parker

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) md

12 MAIDEN NAME OF MOTHER Nancy Rinds

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) md,

14 Informant Walter Parker
(Address) 904 Eden Place

15 Filed NOV 13 1920, 19.....
Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) nov 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1920, to nov 11, 1920, that I last saw h... alive on nov 10, 1920, and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Urinary Analysis

(Signed) Edward H Jones, M. D.

10/11, 1920 (Address) 170 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cem	Nov 14 1920
20 UNDERTAKER	ADDRESS
John H Toadvine	1402 Druid St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. If PHYSICIAN does not know CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING -

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48028 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48028

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Williams

(a) RESIDENCE. No. 536 Dolphin St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Abraham Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Julet Wetherspoon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records, (Address) New City Hospital

Filed NOV 13 1920 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11, 1920

17 I HEREBY CERTIFY, That I attended deceased from October 15, 1920, to November 11 1920. that I last saw h im alive on November 11, 1920. and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Mitral stenosis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) J. B. Hewman, M. D.

11/12/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 14 1920
20 UNDERTAKER John H. Soader	ADDRESS 142 Lisbon St

D.48029 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48029

CERTIFICATE OF DEATH.

REGISTERED No. C 28

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 704 Eund .. St. L WARD)
(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Warner
(Residence in Baltimore: No. 704 Eund st St.)

33 yrs., mos. ds.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M
4-COLOR OR RACE: C
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: ..... (Month) ....., 1 ..... (Day) (Year)

7-AGE, 37 yrs. ..... mos. ..... ds.
If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Steel Co

9-BIRTHPLACE, (State or Country): Pittsburgh Pa

PARENTS.
10-NAME OF FATHER, Ed. Warner
11-BIRTHPLACE OF FATHER (State or Country), Ind
12-MAIDEN NAME OF MOTHER Carrie Bailey
13-BIRTHPLACE OF MOTHER (State or Country), Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Helen Warner
(Address) 704 Eund st

15- Filed NOV 13 1920, 191.....
Robert P. Harrison, Burial Permit Clerk.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH ..... Nov. (Month) 10 (Day), 192 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemorrage of Lungs.
..... (Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Morrison M. D.
(Coroner)
Nov 17 1920 (Address) 1432 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem
DATE OF BURIAL, Nov 19 .....
20-UNDERTAKER Arnold Forbes
ADDRESS 716 E ...

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

20,48030 HEALTH DEPARTMENT—CITY OF BALTIMORE 20,48030

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 240 Rock St. 18 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabel Price

(a) RESIDENCE. No. 240 Rock St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred 15 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced (write the word): Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of:
6 DATE OF BIRTH (month, day, and year): 3/16/1905
7 AGE: Years 15 Months 7 Days 24 If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9 BIRTHPLACE (city or town) (State or country): Balto Md
PARENTS
10 NAME OF FATHER: Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown
12 MAIDEN NAME OF MOTHER: Mary Johnson
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland
14 Informant: Florence Anthony
(Address) 240 Rock St
15 Filed NOV 13 1920 19 Robert P. Harris
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/9/1920
17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1920, to Nov 9, 1920, that I last saw h e alive on Nov 5, 1920, and that death occurred, on the date stated above, at 6.40 p m.
The CAUSE OF DEATH* was as follows:
(a) Pulmonary Tuberculosis
(duration) Months 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Pleurisy
(duration) yrs. mos. 21 ds.
18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. F. Howell M. D.
1920 (Address) 767 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Nov 13 1920
20 UNDERTAKER: Samuel C Fendley — ADDRESS 5 S Bond St

Spec.—8-24-14—M. & T.—2000 Blks.

D.48031 ✓ OK, D.48031

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48031 X 137 M Gorman coroner

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green St. ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isola Lewis.

(Residence in Baltimore: No. Govans Md. St.; ..... yrs., 2 mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

9

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Black	Single

6-DATE OF BIRTH, ... November ..... (Month) ..... (Day), 1900 (Year)

7-AGE, ... 20 ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... nurse 070
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Hoskins N. C.

PARENTS.

10-NAME OF FATHER, Edmond

11-BIRTHPLACE OF FATHER (State or Country), Richmond

12-MAIDEN NAME OF MOTHER Mamie Lewis

13-BIRTHPLACE OF MOTHER (State or Country), Cofield NC.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. E. Mundley

(Address) Cofield N.C.

15- Cofield

Robert P. Harrison,

Filed ..... 191 .....

NOV 18 1920

Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 9 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 8th 1920, to November 9th 1920., that I saw her alive on November 8th 1920, and that death occurred, on the date stated above, at 3.25 A m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicaemia

..... (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. McHenry Mundley M. D.

11/9, 1920 (Address) University Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Cofield North Carolina

19-PLACE OF BURIAL, OR REMOVAL, Hertford Co. N.C. DATE OF BURIAL, 11.13., 1920

20-UNDERTAKER Samuel T. Hemsley ADDRESS 578 N Bridle

Spec.—6-9-19—H. P. Co.—1000 Bks.

10.48032 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.48032

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 3175 S. Highland Ave ST. 76 WARD)

2-FULL NAME Karen Hartwigsen.

(a) RESIDENCE. NO. 3175 S. Highland Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse Hartwigsen.

6 DATE OF BIRTH (month, day, and year) Oct 14 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway.

PARENTS

10 NAME OF FATHER Niles Olsen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway.

12 MAIDEN NAME OF MOTHER Virgine Gulbrand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant Virgine Hansen (Address) 3175 Highland Ave

15 Filed NOV 13 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-11-1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1920 to Nov 11, 1920; that I last saw h[er] alive on Nov 11, 1920, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral- Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John B. Owens, M. D.

Nov-12 1920 (Address) 35 W Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Nov 13 1920
20 UNDERTAKER John Herwig & Co	ADDRESS 2008 Eutaw

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 48033

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48033

CERTIFICATE OF DEATH.

79

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 S. Madeira St. St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Linkowski

(Residence in Baltimore: No. 216 S. Madeira St.; 40 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1860 (Year)

7-AGE, 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Waterman
(b) General nature of industry, business, or establishment in which employed (or employer) D6

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Jno Linkowski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eva x Linkowski
her mark

(Address) 216 S. Madeira St.

15-

Filed ..... 191.....

Robert P. Harrison,
Registrar.

NOV 13 1920
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 11, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 20 1920, to Nov. 11 1920, that I saw him alive on Nov. 10 1920, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Dis. Heart

(Duration) 7 yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Charles A. Greer M. D.

Nov 12, 191... (Address) 405 Hat & K. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus. DATE OF BURIAL, Nov 15, 1920.

20-UNDERTAKER M. F. Sadowski ADDRESS 905 S. Ann

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Gerczak)

D. 48034 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48034

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 102 S. Wolfe ST.; 2 WARD)

2-FULL NAME Annie Gerczak

(a) RESIDENCE. No. 102 S. Wolfe. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Gerczak

6 DATE OF BIRTH (month, day, and year): Jan 14 1870

7 AGE — Years: 50 — Months: 10 — Days: 27 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): — 037

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Adam Brzozowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): John Brzozowski

Robert P. Harrison,

Filed NOV 13 1920 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1920 to Nov 11 1920, that I last saw h alive on Nov 10 1920, and that death occurred, on the date stated above, at 1045 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary): Ascites

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. C. Clado, M. D.

, 19 (Address) 1436 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov 15 1920
20 UNDERTAKER	ADDRESS
John A. Weber	803 Baltimore

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48035 HEALTH DEPARTMENT—CITY OF BALTIMORE D48035

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 212 S. Ann St ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Guzmaki

(a) RESIDENCE. No. 212 S. Ann ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia

6 DATE OF BIRTH (month, day, and year) Unknown 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 04

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mr. Peter Guzmiski

(Address)

15 Filed NOV 13 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1920, to Nov. 11, 1920, that I last saw him alive on Nov. 11, 1920, and that death occurred, on the date stated above, at 9 30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Asthma, senility

(duration) 15 yrs. \ mos. \ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry Linder, M. D.

. 19 (Address) 14 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov 15 1920
20 UNDERTAKER	ADDRESS
John A Weber	1803 Bank

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

20.48036 HEALTH DEPARTMENT--CITY OF BALTIMORE 20.48036

CERTIFICATE OF DEATH

REGISTERED No. C 46

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1472 Stevens St. 24 WARD)

2 FULL NAME Emma V. Wilder

(Residence in Baltimore: No. 1472 Stevens St.; 63 yrs. 6 mos. 28 ds.)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: April 15th, 1857 (Month) (Day) (Year)

7 AGE: 63 yrs. 6 mos. 28 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: James L. Hays

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Charity Lawrence

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma V. Wilder

(Address) 1472 Stevens

15. Filed NOV 13 1920, 191 Robert P. Harrison, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: November 14, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 17, 1920, to November 14, 1920, that I saw h[illegible] alive on November 11, 1920, and that death occurred, on the date stated above, at 5th m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) 7 yrs. mos. 1 ds. from knowledge

Contributory (SECONDARY) about 6 months from History

(Duration) yrs. mos.

(Signed) Thos La Stevens M. D.

Nov 17, 1920 (Address) 2866 Mayfield

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Nov 13, 1920

20 UNDERTAKER: Wm J Calvert Sons

ADDRESS: 14 W Mul[illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

48037 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓48037

CERTIFICATE OF DEATH. 64

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 Cleveland Street ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Elise Streit

(a) RESIDENCE. NO. 1124 Cleveland Street ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) October 8th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10 NAME OF FATHER John Streit

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Elizabeth Ramseyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant Lena Mangold

(Address) 1118 West Cross Street

15 Filed NOV 14 1920 16 ROBERT E. [illegible] Registrar

Burial Permit Oleza

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 12th 1920

17 I HEREBY CERTIFY, That I attended deceased from November 3rd, 1920, to November 12th, 1920, that I last saw her alive on November 11th, 1920, and that death occurred, on the date stated above, at 1.15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Arterio sclerosis

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar Stanley Perkins, M. D.

, 19 (Address) 1 West Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	Nov. 15. 1920
20 UNDERTAKER C. W. Dill	ADDRESS 3109 Fredk. Ave.

RESERVED FOR BINDING

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D. 48038

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48038

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital REGISTERED NO. C

CITY OF BALTIMORE: (NO. ..... ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William R. Phelps

(Residence in Baltimore: No. Laurel Md St.; ..... yrs., ... mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH. May 16, 1919 (Month) (Day) (Year)

7-AGE. 1 yrs. 4 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Infant

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER. Wm A. Phelps

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Ethel Divins

13-BIRTHPLACE OF MOTHER (State or Country), Laurel.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Record

(Address) .....

15- Filed NOV 14 1920, 191.. ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 14 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/10 1920, to 11/14 1920, that I saw h.im alive on 11/14 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial Insuf.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. R. Goldborough M. D.

11/14, 1920 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 ds. In the State 1 yrs. 4 mos. ..... ds.

Where was disease contracted, if not at place of death? Laurel Md

Former or usual residence " "

19-PLACE OF BURIAL OR REMOVAL, Laurel Md — DATE OF BURIAL, 11-15, 1920

20-UNDERTAKER E & B Hade — ADDRESS 115 E Main St

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 GREEN 1048039

HEALTH DEPARTMENT—CITY OF BALTIMORE 1048039

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1104 805 N Hartford St.: 10 WARD)

2-FULL NAME Miller Green

(Residence in Baltimore: No. 805 N Hartford Ave St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, May (Month) 25 (Day) 1920 (Year)

7-AGE, 6 months ..... yrs. 6 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none 000
(b) General nature of industry, business, or establishment in which employed (or employer) ..... none

9-BIRTHPLACE, (State or Country), born in Baltimore

PARENTS.

10-NAME OF FATHER, Thomas Green

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Carrie Gibbs

13-BIRTHPLACE OF MOTHER (State or Country), born in Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Carrie Gibbs

(Address) 805 N Hartford Ave

15- Filed NOV 14 1920, 19.., ROBERT F FRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 12 (Day) 1918 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary) Measles

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) J. A. Weber M. D.
(Coroner.)

11/13/20 191... (Address) 1732 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	Nov 14 19 20
20-UNDERTAKER Wm R. + Elliott	ADDRESS 725 Lanvale st

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48040 ✓ D48040

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Harris

(a) RESIDENCE. No. 526 N. Spring St Baltimore Md. ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 2½ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 9. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER William Harris

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen ?.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant ✓
(Address)

15 Filed NOV 14 1920 ROBERT B. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1920, to Nov 13, 1920, that I last saw h[illegible] alive on Nov 13, 1920, and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Peritonitis, acute

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Diarrhea (not dysentery)

(duration) — yrs. — mos. 20 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Lawson Tiffin, M. D.

Nov 13 1920 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Nov 15, 1920
20 UNDERTAKER	ADDRESS
Wm. Robert A Elliott	[illegible]

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48041 HEALTH DEPARTMENT—CITY OF BALTIMORE D48041

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 613 N. Lakewood Ave ST.: 7 WARD)

REGISTERED No. 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred E. Lassen

(a) RESIDENCE. No. 613 N. Lakewood Ave ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 6, 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Henry J. Lassen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Catherine Elgert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Henry J. Lassen
(Address) 613 N. Lakewood ave

15 Filed NOV 14 1920 19 (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 1920

17 I HEREBY CERTIFY, That I attended deceased from 11—9, 1920, to 11—14, 1920, that I last saw her alive on 11—13, 1920, and that death occurred, on the date stated above, at 6:45 A M m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J. Russell, M. D.

19 (Address) 156 N. Bullitt Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. — DATE OF BURIAL: Nov 16 19 20

20 UNDERTAKER: H. Sander Sons — ADDRESS: 1116 Park Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

1048042

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048042

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2105 E. Madison (St.:) 7 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Milske

(a) RESIDENCE. No. 2105 E. Madison St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. Milske

6 DATE OF BIRTH (month, day, and year) Oct 24 / 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home 000

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Salem N. J.

PARENTS

10 NAME OF FATHER: Chas. E. Werner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Margaret Volk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant: Mr. George Milske

(Address) 2105 E Madison

15 Filed NOV 14 1920 19.... [illegible]

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1920, to Nov 12, 1920, that I last saw h[illegible] alive on Nov 12, 1920, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

Nephritis (duration) 5 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood pressure & urinary findings

(Signed) Wm B Luman, M. D.

11/13 1920 (Address) 718 N Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Nov. 15 1920

20 UNDERTAKER: Jos. J. Ilen — ADDRESS: 1564 N. Luzerne Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1048043 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048043

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2502 Shirley ave. St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Estella E. Whitley

(Residence in Baltimore: No. 2502 Shirley ave. St.; all lifetime yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Fem.	White	Single

6-DATE OF BIRTH, September 27nd, 1878
(Month) (Day) (Year)

7-AGE, 41 yrs. 1 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse 048
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, David H. Whitley

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Annie E. Orchard

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David H. Whitley Jr.

(Address) 3720 Park Heights ave.

15- Filed NOV 14 1920 ROBERT F. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 12, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1920, to Nov. 12 1920, that I saw her alive on Nov. 11 1920, and that death occurred, on the date stated above, at 5:40 P. m.

The CAUSE OF DEATH* was as follows:

Heart disease (Mitral regurgitation)

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. E. Tremwell M. D.

Nov. 12, 1920 (Address) 2226 Madison ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
London Park Cem.	Nov. 15, 1920
20-UNDERTAKER	**ADDRESS**
Wm. E. Black	927 N. Broadway

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048044

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048044

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Marlborough Aprt., ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Goldscheider,

(a) RESIDENCE. No. Eutaw Place & Wilson St., ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female,	White	Widow,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hugo A. Goldscheider,

6 DATE OF BIRTH (month, day, and year) July 30th. 1861.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none, 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Emanuel E. Rheine,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany,

12 MAIDEN NAME OF MOTHER Rachel Hartman,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany,

14 Informant (Address) Mrs. Steinberg, Marlboro, Aprt.

15 Filed NOV 14 1920 ROBERT B. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13th. 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec 16 1919, to Nov 13 1920, that I last saw h 2 alive on Nov 12 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Diabetes 16 years

Chronic Nephritis (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Dora V. Hamburger, M. D.

Nov 13. 1920 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew,	Nov. 15th. 19
20 UNDERTAKER Harry Sondheim	ADDRESS 1117 W. Lexington

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048045 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048045

CERTIFICATE OF DEATH. 92-10

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 N. Chase ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Scott

(a) RESIDENCE. No. 216 N. Chase ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ben Scott

6 DATE OF BIRTH (month, day, and year) Mar 11-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Ben Cutler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lobrinda Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Amanda Scott (Address) 216 N. Chase

15 Filed NOV 14 1920 19 ROBERT V. KRUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 19 20

17

I HEREBY CERTIFY, That I attended deceased from Nov 9, 19 20, to Nov 11, 19 20, that I last saw h... alive on Nov 11, 19 20, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. C. Burns, M. D.

11-13-20 (Address) 2-21 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Petersburg Va	Nov 14 1920
20 UNDERTAKER Daniel Taylor	ADDRESS 916 Pa ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048046

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1048046

28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Stepney

(a) RESIDENCE. No. 1519 Myrtle Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Stepney

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Amelia Butler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed NOV 14 1920, 19 ROBERT J. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11, 1920

17

I HEREBY CERTIFY, That I attended deceased from November 6, 1920, to Nov. 11, 1920, that I last saw her alive on November 11, 1920, and that death occurred, on the date stated above, at 3.10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. J. Regney, M. D.

11-11-20. 19 (Address) Muncipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 14 1920
20 UNDERTAKER JAMES H. DENNIS	ADDRESS 1303 PRESTMAN ST

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1948047

HEALTH DEPARTMENT—CITY OF BALTIMORE

1948047

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

REGISTERED NO. 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Johnson

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED 040

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records,
(Address) New City Hospital.

15 Filed NOV 14 1920 ROBT. J. KRAMER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 12, 1920

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1920, to November 12 1920.

that I last saw him alive on November 12, 1920.

and that death occurred, on the date stated above, at 10:20 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (no autopsy)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) Jack. L. Morgan, M. D.

11/12/1920 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Nov 15 1920

20 UNDERTAKER: JAMES H. DENNIS — ADDRESS: 1303 PRESTMAN ST.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48048 HEALTH DEPARTMENT—CITY OF BALTIMORE D48048

CERTIFICATE OF DEATH. 120

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 Wallbrook Ave St.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Burkhart

(a) RESIDENCE. No. 2108 Wallbrook Ave St.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin Burkhart

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 1900

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Brantz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Rose Wagner (Address) 2105 Wallbrook Ave

15 NOV 14 1920 ROBERT J. KNITTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11th 1920.

17 I HEREBY CERTIFY, That I attended deceased from 9 A.M. Nov. 11th 1920. to 12 Noon, Nov. 12th 1920. that I last saw her alive on Nov. 11th 1920 and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Chronic nephritis.

Several (Vocational) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic Coma (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? Urinalyses etc.

(Signed) O. H. Hoffman M. D.

11/12 1920 (Address) 2100 N. Monastery Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem.	Nov. 15 1920
20 UNDERTAKER	ADDRESS
Martin Fuhey & Sons	827 N. Howard

Spec.—8-24-14—M. & T.—2000 Bks.

1048049

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048049

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Taylor's Lane ST.; W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Agnes Avery-

(Residence in Baltimore: No. 6 Taylor's Lane- St.; 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-~~SINGLE,~~ MARRIED, ~~WIDOWED, OR DIVORCED,~~ (Write the word.) married

6-DATE OF BIRTH, Jan. 17, 1899 (Month) (Day) (Year)

7-AGE, 21 yrs. 9 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): Pvt

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Abraham E. Hall

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Clara B. Harding

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Clara B. Hall

(Address) 6 Taylor Lane

15- NOV 14 1920 Filed....., 191.... ROBERT B KRAUTER Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov- 13 — (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Nov- 13-1920, that I saw her alive on Nov 13 1920, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Ac Pulmonary Tuberculosis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Acquired Infection

(Duration) yrs. mos. ds.

(Signed) Edw Short M. D.

Nov. 14, 1920 (Address) 1812 David Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death life mos. ds. In the State life mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Star (Balto Co) DATE OF BURIAL, Nov. 16, 1920

20-UNDERTAKER Easton Sons ADDRESS Ellicott City

N.B.—Every item of information should be carefully supplied. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 48050

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48050

CERTIFICATE OF DEATH.

X 120

1-PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 507 N. Welcome Alley ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Krashears. (C)

(Residence in Baltimore: No. 507 N. Welcome Alley. St.; - yrs., - - - mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored	Widow.

6-DATE OF BIRTH,

Do not Know. (Month) , 1 (Day) (Year)

7-AGE, 50 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None. 000
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Calvert Co. Md.

PARENTS.

10-NAME OF FATHER, John R. Coates. (C)

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co. Md.

12-MAIDEN NAME OF MOTHER Sarah Johnson. (C)

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grace Reed. (C) daughter.

(Address) 507 N. Welcome Alley.

15- Filed NOV 15 1920, 191... ROBERT B KRAUTER Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 13th. 1920., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Eisenhardt M. D.
(Coroner.)

Nov. 14., 1920. (Address) 1017 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Annapolis Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Arundel Mem'l	Nov. 17 1920
20-UNDERTAKER Pinkney Cemetery Edward Pinkney	ADDRESS 1463 Carey

D48051 HEALTH DEPARTMENT—CITY OF BALTIMORE D48051

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1313 Stockton ST. 15 WARD) 79 REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Campbell

(Residence in Baltimore: No. 1313 Stockton St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX female | 4-COLOR OR RACE, colored | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, January 1, 1905 (Month) (Day) (Year)

7-AGE, 15 yrs. 11 mos. 13 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none 000
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Joshua Campbell

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Maggie Hawkins

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joshua Campbell

(Address) 1313 Stockton St.

Filed NOV 15 1920, 191.... ROBERT B KRAUTER Registrar of Vital Statistics

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 13, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~autopsy~~ inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. D. Hennessy M. D. (Coroner.)

Nov. 14, 1920 (Address) 2807 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn | DATE OF BURIAL, Nov. 15 19 20

20-UNDERTAKER Brown & Sons | ADDRESS 114 N

N. B.—Every item of information should be carefully supplied. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

State—6-9-19—H. P. Co.—1000 Bks.

0948052

HEALTH DEPARTMENT—CITY OF BALTIMORE

0948052

CERTIFICATE OF DEATH.

74

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3807 Hamilton Ave ST.: ~~28th~~ 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jrchain Henry Davidson

(a) RESIDENCE. No. 3807 Hamilton Ave ST., ~~28th~~ WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 14 mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Matty Davidson

6 DATE OF BIRTH (month, day, and year) May 2 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dorchester Co
(State or country) Md

PARENTS

10 NAME OF FATHER Wm Henry Davidson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Ella Meredith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Matty Davidson
(Address) 3804 Hamilton ave

Filed NOV 15 1920 ROBERT R. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14th 1920

17

I HEREBY CERTIFY, That I attended deceased from Oct 10th, 1920, to Nov 14th, 1920, that I last saw him alive on Nov 13th, 1920, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Tumor of Brain

(duration) yrs. 2 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) A. C. Emmick, M. D.

Nov 14th 1920 (Address) 4309 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	Nov 16 1920

20 UNDERTAKER Sr. Weber & Son ADDRESS 2503 Druid Hill Ave

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048053

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048053

37

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 S. Charles ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Buchanan Grimes

(a) RESIDENCE. NO. 620 S. Charles ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Martha Grimes

6 DATE OF BIRTH (month, day, and year) Feb 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	—	—	

8 OCCUPATION OF DECEASED 186

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) M Steamboat

(c) Name of employer Stoke Keeper

9 BIRTHPLACE (city or town) (State or country) Richmond / Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Martha Grimes
(Address) 620 S Charles

15 NOV 15 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 19 20

17 I HEREBY CERTIFY, That I attended deceased from Nov 10th, 1920, to Nov 12, 1920, that I last saw h~~is~~ alive on Nov 12, 1920, and that death occurred, on the date stated above, at 9.10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease (Aortic Insufficiency) Duration 1 year

CONTRIBUTORY (Secondary) Heart Block (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy Pathologic Examination

(Signed) O'Hanlon M. D.

11-14 1920 (Address) 140 W. Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cremation with Northumberland Co. Va	Nov 15 1920
20 UNDERTAKER John H. Toadvine	ADDRESS 142 Westiel St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048054 ✓1048054

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Preston Apartments

CITY OF BALTIMORE: (No. Guilford Ave + Preston ST.: 17 WARD) 40

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Alice May Nash

(a) RESIDENCE. NO. Preston Apt. Guilford Ave + Preston ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. A. Nash

6 DATE OF BIRTH (month, day, and year): May 18-1867

7 AGE — Years: 53 — Months: 5 — Days: 27 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore. Md.

PARENTS

10 NAME OF FATHER: George Gosnell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Md.

12 MAIDEN NAME OF MOTHER: Sarah Simmons

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co. Md.

14 Informant (Address): Wm. A. Nash, Preston Apartments

15 NOV 15 1920 ROBERT B KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 14 1920

17 I HEREBY CERTIFY, That I attended deceased from April, 1917, to Nov. 14, 1920 that I last saw h[illegible] alive on Nov. 14, 1920 and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus and of Stomach

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) General Carcinomatosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X'ray, Gastric analysis etc

(Signed) Herbert M. Foster, M. D.

, 19 (Address) 44 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: Nov. 17 1920

20 UNDERTAKER: Horace Burdette Son

ADDRESS: 43 Fallsway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

0148055 HEALTH DEPARTMENT—CITY OF BALTIMORE 0148055

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 N. Mount ST.; 16 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank William Sullivan

(Residence in Baltimore: No. 908 Mount St. St.; — yrs., — mos. 38 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Baby

6-DATE OF BIRTH, Oct 7, 1920. (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
..yrs. — mos. 38 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... baby.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Frank R. Sullivan

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Anna C. Forch

13-BIRTHPLACE OF MOTHER (State or Country), New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank R. Sullivan

(Address) 908 Mount

15- NOV 15 1920 ROBERT B KRAUTER

Filed....., 191.... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 14, 1920. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 13 1920, to Nov 14 1920, that I saw him alive on Nov. 13 1920, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Marasmus

Life

(Duration)....yrs....mos....ds.

CONTRIBUTORY.....
(Secondary)

(Duration)....yrs....mos....ds.

(Signed) Charles F. Clark M. D.

Nov 14, 191.. (Address) 1306 N. Gilmor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Nov 15, 1920

20-UNDERTAKER, John C. Mitchell — ADDRESS 2011 W. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48056

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48056

CERTIFICATE OF DEATH.

154

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4103 Belvieu Av. St.: 15 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Jane Smith

(a) RESIDENCE. No. 4103 Belvieu Av St. 15 Ward. (Resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 5 mos. 17 ds. How long in U. S., If of foreign birth? 77 yrs 5 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas K Smith

6 DATE OF BIRTH (month, day, and year) May 27 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm J. Barton

11 BIRTHPLACE OF FATHER (city or town) Harford Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann Lees

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr Harry M. Smith (son)
(Address) 3835 Old Frederick Ave.

15 Filed NOV 15 1920 ROBERT E KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 13 1920

17 I HEREBY CERTIFY, That I attended deceased from NOV. 10, 1920, to NOV 13, 1920

that I last saw he alive on NOV 12, 1920,

and that death occurred, on the date stated above, at 3.30 m.

The CAUSE OF DEATH* was as follows:

Senility

Duration (duration) 3 yrs. ~ mos. ~ ds.

CONTRIBUTORY (Secondary) None (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? ~ Date of ~

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Vernon A. Condon, M. D.

, 19 (Address) 750 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Nov. 15 1920

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1048057 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048057

CERTIFICATE OF DEATH.

79

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2221 McHenry, St.: 70 Ward)

2-FULL NAME Cleopha Schmidt

(a) RESIDENCE. No. 2221 McHenry St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. — mos. — ds. How long in U. S., if of foreign birth? 63 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of John Schmidt

6 DATE OF BIRTH (month, day, and year) May 20-1836

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —— 608

(b) General nature of Industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fred L Schmidt

(Address) 2221 McHenry St

Filed NOV 15 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1920

17 I HEREBY CERTIFY, That I attended deceased from August, 1920, to Nov 13, 1920; that I last saw h[illegible] alive on Nov 13, 1920; and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH* was as follows: Arteriosclerosis, Cardiac dilatation, Mitral insufficiency

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Usual Clinical

(Signed) Thomas J Abell M. D.

, 19 (Address) Medical Soc. Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 16/ 1920

20 UNDERTAKER J B Kippert ADDRESS 2236 Eutaw

Should be stated EXACTLY. PHYSICIANS should state terms, so that it may be properly classified. Exact statement of OCCUPATIONS important. See instructions on back of certificates.

D48058 HEALTH DEPARTMENT—CITY OF BALTIMORE D48058

CERTIFICATE OF DEATH. 175-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Agnes Hospital WARD)

2-FULL NAME Sister E. Gerard,

(Residence in Baltimore: No. 645 N Fulton Ave

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

6 St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W.	Married

6-DATE OF BIRTH, March (Month) 3 (Day) 1865 (Year)

7-AGE, 55 yrs. mos. da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Nun
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country), England

PARENTS.

10-NAME OF FATHER, Wm Green

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Charlotte Cook

13-BIRTHPLACE OF MOTHER (State or Country) England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Green

(Address) 645 N. Fulton Ave

15- NOV 15 1920 Filed, 191 ROBERT B KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 12 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to August death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto accident

Fracture of ribs

(Duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. 1 da.

(Signed) F. C. Blades M. D.

(Coroner.)

11/13/20 191 (Address) 143 N. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cemetery	Nov 15, 1920
20-UNDERTAKER George J Smith	ADDRESS 1000 Fayette St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-3-19—H. P. Co.—1000 Bks.

D48059 HEALTH DEPARTMENT—CITY OF BALTIMORE D48059

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2026 E. 31st St.: 9 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia J. Wheeler

(a) RESIDENCE. No. 2026 E. 31st St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Female~~

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: the late John W. Wheeler

6 DATE OF BIRTH (month, day, and year): June 22/45

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

PARENTS

9 BIRTHPLACE (city or town) (State or country): Dorchester Co Md.

10 NAME OF FATHER: Robt. Hubbard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Louisa Seward

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Robt. J. Wheeler

(Address) 2626 E. 31st St

15 Filed NOV 15 1920 ROBERT B KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1920, to Nov 14, 1920, that I last saw h[illegible] alive on Nov 13, 1920, and that death occurred, on the date stated above, at 5A, m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Hypostatic Pneumonia

(duration) 0 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Cochran, M. D.

Nov 15, 1920 (Address) 3100 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md.	Nov 15 1920
20 UNDERTAKER: Philip Herwig	ADDRESS 2016 Orleans

Spec.—8-24-14—M. & T.—2000 Bks.

D48060

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48060

CERTIFICATE OF DEATH.

42

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 747 Wilson ST. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emerie Lattimore

(Residence in Baltimore: No. 747 Wilson St.; 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ...1874...., 1 (Month) (Day) (Year)

7-AGE, 46 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic Duty
(b) General nature of industry, business, or establishment in which employed (or employer) Private

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Nelson Keys

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Susan

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emerie Lattimore

(Address) 747 Wilson St

15-

Filed NOV 15 1920 ROBERT B KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 11th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1920, to Nov. 11th 1920, that I saw h[illegible] alive on Nov. 11th, 1920, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Cervix Uteri

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 1 mos. ds.

(Signed) [illegible] M. D.

11/12, 1920 (Address) 742 Mad[illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, 11.15.14, 1920.

20-UNDERTAKER Edw. Langgold — ADDRESS 1463 Carey St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48061

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

64 D48061

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 S. Dallas ST.: 3 WARD)

2-FULL NAME Wm H. Wheatley

(a) RESIDENCE. No. 119 S. Dallas ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	W, Dawed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of [illegible]

6 DATE OF BIRTH (month, day, and year) ~~93~~ 1827

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
93	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Old Soldier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ned Wheatley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Francis Martin

(Address) 119 S. Dallas

15 Filed NOV 15 1920 . 19 ROBERT P. LAZENBY Registrar

Burial Permit Ord

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 19 20

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31 . 19 20 . to Nov. 11 . 19 20

that I last saw him alive on Nov 11 . 19 20 .

and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Mitral Incompetency
Cerebral Hemorrhage
Aortic Insufficiency

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Linder, M. D.

, 19 (Address) 141 S. Broadway,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
U S National Cem	Nov 15 19 20
20 UNDERTAKER Mrs Robt A Elliott	ADDRESS 1728 Eastland Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

2048062

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

2048062

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 S. Dallas ST.: 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jonyencowsky

(a) RESIDENCE. No. 427 S. Dallas ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 17/1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	11	17	

040

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Shipyard

(c) Name of employer Globe Ship Co

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Peter Jonyencowsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Helen Bartkevicius

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Helen Bartkevicius (Address) 427 S. Dallas

15 NOV 15 1920 ROBERT E. LEACHER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1920.

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1920, to Nov 13, 1920, that I last saw him alive on Nov 12, 1920, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry F. Lincoln, M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov 16 19
20 UNDERTAKER	ADDRESS
Mendell & Cypel	3/4 Cen

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1048063 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048063

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Little Sisters of the Poor 1.0 WARD)

REGISTERED NO. C 79

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Krein

(Residence in Baltimore: No. Preston & Valley Sts. St.; yrs., 72 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, ..., 1848.
(Month) (Day) (Year)

7-AGE, 72 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Laurence Krein

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Susanne Menge

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister F. Lazarus

(Address) Preston & Valley Sts

15-

Filed NOV 15 1920, 191.... ROBERT E. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 13th Nov., 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Tuckey M. D.
(Coroner)

....., 191... (Address) City

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 5 yrs. 6 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Peters	Nov. 16, 1920

20-UNDERTAKER	ADDRESS
H. C. Wedefeld	914 Greenmount Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D48064 Bowie D48064

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Prince Hollins St.: 225 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos W Bowie

(Residence in Baltimore: No. Prince Hollins St.; 2 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	Colr	Married

6-DATE OF BIRTH, 3 (Month) 7 (Day), 1853 (Year)

7-AGE, 57 yrs. 8 mos. 4 da. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): G&O

9-BIRTHPLACE, (State or Country), D. C.

PARENTS.

10-NAME OF FATHER, Blossett Bowie

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Matilda Hamond

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Bowie

(Address) Woods P.O. Md

15- Filed NOV 15 1920, 191.. ROBERT E KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 12 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9. 12 1920, to Nov 11 1920, that I saw h[illegible] alive on Nov 11 1920, and that death occurred, on the date stated above, at 930 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Nephritis
Cancer of stomach

(Duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Intestinal

(Duration) yrs. mos. da.

(Signed) Thos E Hall M. D.

11-12, 1920 (Address) Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 50 yrs. mos. ds. In the State 50 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, Nov 15, 1920

20-UNDERTAKER Jos G. H. Horser

ADDRESS 406 N Carey St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048065 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048065

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 3153 Ellamont St.: 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David F. Humphrys

(a) RESIDENCE. No. 3153 Ellamont St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Humphrys

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About	72 Yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. David Humphrys

(Address) 3153 Ellamont St

15 Filed NOV 15 1920 19 ROBERT B LEATHERBURY Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5, 19 20, to Nov 14, 19 20, that I last saw h— alive on Nov 13, 19 20, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Intestitial Nephritis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W Jones M. D.

19 (Address) Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov: 15. 1920
20 UNDERTAKER C. W. Dill	ADDRESS 3109 Fredk. Ave:

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1048066 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048066

42

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1506 Hollins ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hester Helvina Smith.

(Residence in Baltimore: No. 1506 Hollins St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 18, 1862 (Month) (Day) (Year)

7-AGE. 58 yrs. 5 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Housework (b) General nature of industry, business, or establishment in which employed (or employer). Home

9-BIRTHPLACE. (State or Country). Md. Co Md.

PARENTS.

10-NAME OF FATHER. James M Rourke

11-BIRTHPLACE OF FATHER (State or Country). Md Co Md

12-MAIDEN NAME OF MOTHER Mary Ann Lucas.

13-BIRTHPLACE OF MOTHER (State or Country). Md Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A Smith

(Address) 1506 Hollins St.

15-Filed NOV 15 1920 ROBERT B KRAUTER Registrar. 031 BURIAL PERMIT Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 14, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1 1919, to Nov 13 1920, that I saw h-er alive on Nov 13 1920 and that death occurred, on the date stated above, at 5.30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) one year yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Walter A Coe M. D.

11-17-, 1920. (Address) 54 Hutton Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park. DATE OF BURIAL. Nov 16 1920

20-UNDERTAKER Putnam & Coe E. ADDRESS 1129 N. Eutaw St

Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48067

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48067

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 Union Ave ST. 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert N. Hornsby

(a) RESIDENCE. No. 1603 Union Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Hornsby

6 DATE OF BIRTH (month, day, and year) Jan 29 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Hornsby

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Ada E. Hornsby (Address) 1603 Union Ave

15 NOV 15 1920 EDGAR F. ADLER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st 1920 to Nov 11 1920 that I last saw him alive on Nov 11 1920 and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhage - Malnutrition

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of Death

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) Wm F Kelly M D M. D.

Nov 13 1920 (Address) 3105 Jack Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Nov 13 1920

20 UNDERTAKER Chenoweth & Son ADDRESS Chestnut

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48068

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48068

CERTIFICATE OF DEATH.

REGISTERED No. C 151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1- S. Smallwood St. ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME (Infant) Hrabak

(Residence in Baltimore: No. 1- S. Smallwood St. Brooklyn St.; ....yrs., ...mos. ....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	W	Single

6-DATE OF BIRTH, Nov (Month) 8 (Day), 1920 (Year)

7-AGE,	If LESS than 1 day,
....yrs. ....mos. 7 da.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Andy Hrabak

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Annie L. Davis

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andy Hrabak

(Address) Brooklyn Md

15- NOV 15 1920 ROBERT I KRAUTH

Filed ....., 191.... Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 14 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 8 1920, to Nov 14 1920, that I saw h... alive on Nov 1 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ....yrs. ....mos. ....da.

(Signed) Thomas F Forrester M. D.

Nov 14, 1920 (Address) Brooklyn Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cemetery	Nov 15, 1920
20-UNDERTAKER John F Denny	ADDRESS 715 Light St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D48069

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48069

CERTIFICATE OF DEATH.

79 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital. ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Cooper

(Residence in Baltimore: No. 1814 E. Madison St.; 15 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) — (Day) 1890 (Year)

7-AGE, 30 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Louis Fox

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Sarah —

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1411 E. Balto. St.

15- Filed NOV 15 1920, 191 ROBERT B KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 14 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from November, 1920, to November 14 1920, that I saw h[er] alive on November 1920, and that death occurred, on the date stated above, at 4.40 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

Chronic Endocarditis

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 3 ds.

(Signed) B Jacks M. D.

Nov. 15, 1920 (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? At home

Former or usual residence 1814 E Madison St.

19-PLACE OF BURIAL, OR REMOVAL. Hebrew Hgts Cem. DATE OF BURIAL. 11-15, 1920

20-UNDERTAKER Jack Lewis ADDRESS 1411 E. Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48070 HEALTH DEPARTMENT—CITY OF BALTIMORE D48070

CERTIFICATE OF DEATH. -91

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 18 Elm. Str ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wojcicki

(a) RESIDENCE. No. 18 Elm Str ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7-1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10 NAME OF FATHER John Wojcicki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Downarska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Wojcicki (Address) 18 Elm Str

15 NOV 15 1920 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 13th, 1920, to Nov 13th, 1920, that I last saw him alive on Nov 13th, 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Congestion Lungs

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary)

(doration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Thos. B. Horton M. D.

, 19 (Address) Curtis Bay. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cross	Nov. 16 1920
20 UNDERTAKER	**ADDRESS**
Wm. Hallowell's	1618 Eastern Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE CAUSING DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably
Broncho Pneumonia
No other Infection.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48071

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48071

37

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 S. 7th St.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rocco Petrelli

(a) RESIDENCE. NO. 204 S. 7th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): October 11. 20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: — 000

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Louis Petrelli

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Annie Passano

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Louis Petrelli (Address) 204 S 7th St

15 Filed NOV 15 1920 19 Robert P. Harris Registrar
(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1920, to Nov. 17, 1920, that I last saw h[illegible] alive on Nov. 14, 1920, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Asthenia due to
Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Burns M. D.

11.15. 1920 (Address) 827 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem — DATE OF BURIAL: Nov 16 1920

20 UNDERTAKER: J Henry & Co — ADDRESS: 2208 Aisquith

Information should be carefully supplied. AGE should be stated EXACTLY. NAMES should state what it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D. 48072

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48072 HEALTH DEPARTMENT—CITY OF BALTIMORE

39

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. City Hospitals ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Harris

(a) RESIDENCE. No. 1236 W. Cross ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed (write the word)
Male	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Harris

6 DATE OF BIRTH (month, day, and year) Jan 29 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Maryland

PARENTS

10 NAME OF FATHER Jacob Harris.

11 BIRTHPLACE OF FATHER (city or town) Frederick Co (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Delia Walsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Julia Harris

(Address) 1236 W Cross St

Filed NOV 15 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 14 1920

17 I HEREBY CERTIFY, That I attended deceased from 8 - 12, 1920, to 11-14, 1920, that I last saw h[illegible] alive on 11-14-20, 1920 and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lip

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) See. anemia & cachexia (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation preeede death? No Date of

Was there an autopsy? not as yet

What test confirmed diagnosis? Clinical see.

(Signed) F. A. Holden, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodsboro Md.	Nov 17" 1920
20 UNDERTAKER Cecil B. Cook	ADDRESS 1003 W Fallo St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48073 HEALTH DEPARTMENT—CITY OF BALTIMORE D48073

CERTIFICATE OF DEATH. X138

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes' H. (St.) (Ward)

2-FULL NAME Mrs. Annie Martin

(a) RESIDENCE. No. Franklintown St. Woodlawn, Md
(Usual place of abode)
Length of residence in city or town where death occurred 15 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Martin

6 DATE OF BIRTH (month, day, and year) Sept. 5. 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co Md

PARENTS

10 NAME OF FATHER Wm. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co Md

12 MAIDEN NAME OF MOTHER Florence Keck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co Md

14 Informant Mr. Geo. Martin (Address) Woodlawn Md

15 Filed NOV 15 1920 Robert P. Harrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1920, to Nov 13, 1920, that I last saw h[illegible] alive on Nov 13, 1920, and that death occurred, on the date stated above, at 1:20 p.m.

The CAUSE OF DEATH* was as follows:

Eclampsia of Childbirth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) W M Craig M. D.

11/13, 1920 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Nov 16 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Baltimore St

CAUSE OF DEATH in plain terms. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.48074

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48074

CERTIFICATE OF DEATH.

9-091

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. No. WARD)

2-FULL NAME Annie May Funk

(a) RESIDENCE. No. 3502 Mt Pleasant Ave WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 2 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 19-1917

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min
3	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 000

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER David Funk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER Rose Tuffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant David A Funk
(Address) 3502 Mt Pleasant Ave

15 Filed NOV 15 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1920, to Nov 15, 1920
that I last saw her alive on Nov 14, 1920,
and that death occurred, on the date stated above, at 5:15 a m.
The CAUSE OF DEATH* was as follows:

Diptheria, nasal, tonsilar pharyngeal & laryngeal

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 8 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Cultures.

(Signed) R Macfarlan, M. D.
Nov 15 1920 Address) Sydenham Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Nov 16 1920
20 UNDERTAKER	ADDRESS
Jas. C. Rutter	2334 Jefferson St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D.48075 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48075

CERTIFICATE OF DEATH. 113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2040 Bank ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anton Goldberg.

(a) RESIDENCE. NO. 2040 Bank St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PHYSICIANS should be careful in filling out this certificate. All questions should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Teresa

6 DATE OF BIRTH (month, day, and year) March 19 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Jakub Goldberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Bujak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Teresa Goldberg

(Address) 2040 Bank St

Filed NOV 15 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-13 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Nov 13 1920.

that I last saw him alive on Nov 11 1920.

and that death occurred, on the date stated above, at 10-55 P. m.

The CAUSE OF DEATH* was as follows:

Hodgkin's disease

(duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Geo Dutton Bloodgood, M. D.

(Address) 1426 N Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov 17 1920

20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48076 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48076

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 416 Gittings ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Drucella Reed

(a) RESIDENCE. No. 416 Gittings ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 1 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
64	9	12		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None sup

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER L Ramsom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known.

12 MAIDEN NAME OF MOTHER Sims

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Wilms (Address) 416 Gittings

15 DATE RECEIVED NOV 15 1920

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1st 1919 to Nov 13 1920 that I last saw her alive on Nov 13 1920, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Chr. tuberculosis nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myo-carditis & Sclerosis Coronary (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) L. E. Shepard, M. D.

Nov 15 1920 (Address) 1235 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine E J Fanning & Son	Nov 16 19
20 UNDERTAKER	ADDRESS
1938 E Lafayette ave	

Should be carefully supplied. AGE should be stated EXACTLY. PLURALS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48077

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48077

151

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 N. Eutaw St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME No. Name — Baby Frank.

(Residence in Baltimore: No. 607 N. Eutaw St.; ....yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, White (Gypsy)

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct (Month) 31 (Day), 1920 (Year)

7-AGE, ...yrs....mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto. City.

PARENTS.

10-NAME OF FATHER, Mihi Frank.

11-BIRTHPLACE OF FATHER (State or Country). S. America

12-MAIDEN NAME OF MOTHER Annie Stevens.

13-BIRTHPLACE OF MOTHER (State or Country). S. America.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Frank

(Address) 607 N. Eutaw St.

15-

Filed NOV 15 1920, 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 14 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 31 1920, to Nov 14 1920, that I saw h[illegible] alive on Nov 14 1920, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Marasmus Contr. to
poor care & exposure

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Wm. H. Mayers M. D.

....., 191... (Address) 14 E. Mulb St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL, Nov 16, 191..

20-UNDERTAKER, Robert Brockerman ADDRESS 175 Calhoun

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48078 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48078

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3701 Mt. Pleasant Ave. St.) 26 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Tease

(a) RESIDENCE. NO. 3701 Mt. Pleasant Ave. St. WARD. 26

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Pasquale Tease

6 DATE OF BIRTH (month, day, and year): Dec. 8, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Luigi Frotta

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Vittoria Gottola

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Pasquale Tease

(Address) 3701 Mt. Pleasant Ave.

15 Filed NOV 15 1920, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 14, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8 1920, to Nov. 14, 1920, that I last saw h— alive on Nov. 12, 1920, and that death occurred, on the date stated above, at 6:30 A. M.

The CAUSE OF DEATH* was as follows:

Grippe

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleurisy (sicca)

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Hellman M. D.

Nov. 14, 1920 (Address) 827 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincents Cem.	Nov. 16 1920
20 UNDERTAKER: Lilly & Son	ADDRESS: 1103 W. Lafayette Ave.

...should be stated EXACTLY. AGE should be carefully supplied. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48079 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 48079

CERTIFICATE OF DEATH. 64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 626-Fair Oak ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph O. Lopez

(a) RESIDENCE. NO. 626-Fair Oak ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 4A mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~ Widowed, or ~~Divorced~~ (write the word): Widower

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Nellie Lopez.

6 DATE OF BIRTH (month, day, and year) 9/9/1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	2	4	

8 OCCUPATION OF DECEASED 088

(a) Trade, profession or particular kind of work: Retired Hammermaker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Lopez

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER Mary Goetz.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant Hans Lopez. (Address) 626 Fair Oak Ave

15 Filed NOV 15 1920 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 11th, 1920, to Nov 13th, 1920, that I last saw him alive on Nov 13th, 1920, and that death occurred, on the date stated above, at 4-10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. A. Fleet M. D.

11/14 1920 (Address) 176 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Maynard Cemetery, A. A. Co.	11/16 20 19

20 UNDERTAKER George J. Puth ADDRESS 1735 Hanford Ave

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D.48080 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48080

105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE: (No. University Hospital St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Cassell

(Residence in Baltimore: No. 119 Callender St. St.; 33 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH. December 7, 1886 (Month) (Day) (Year)

7-AGE. 33 yrs. 11 mos. 7 ds. — If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): Wood Worker

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER. Chas. H. Cassell

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Rosie Alexander

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles C. Cassell

(Address) 119 Callender St

15- Filed NOV 15 1920, 191. Robert P. Harrison, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 14, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 10 1920, to Nov. 14 1920, that I saw h[illegible] alive on Nov. 14 1920, and that death occurred, on the date stated above, at 2:25 a.m.

The CAUSE OF DEATH* was as follows:

Perforating Duodenal ulcer with Hemorrhage - Operation Gastro-Enterostomy

about 6 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Post-operative pneumonia (Duration) yrs. 2 mos. ds.

(Signed) [illegible] M. D.

Nov 14, 1920 (Address) University Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. mos. 21 ds. In the State 33 yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 119 Callender St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western	Nov. 16., 1920
20-UNDERTAKER	ADDRESS
Geo W Little	531 N Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48081

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48081

CERTIFICATE OF DEATH.

74

1-PLACE OF DEATH Physps Clin. Johns Hopkins Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: H.P. 16 (WARD) N T

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew MacNeal

(Residence in Baltimore: No. 3032 Baker st Balt Md St.: 51 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	married

6-DATE OF BIRTH, July 1st, 1869. (Month) (Day) (Year)

7-AGE, 51 yrs. 4 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Painter 063
(b) General nature of industry, business, or establishment in which employed (or employer)..... Printing

9-BIRTHPLACE, (State or Country), Maryland (Balt Md)

PARENTS.

10-NAME OF FATHER, Chas. MacNeal

11-BIRTHPLACE OF FATHER (State or Country), Balt. Md

12-MAIDEN NAME OF MOTHER Susan Knick

13-BIRTHPLACE OF MOTHER (State or Country), Balt Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm B. Hohman

(Address) Johns Hopkins Hospital

15- Robert P. Harrison,

Filed NOV 15 1920, 191.. Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 14, 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1920, to Nov 14 1920, that I saw him alive on Nov. 13 1920, and that death occurred, on the date stated above, at 8.00 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor (left temporal lobe)

(Duration) yrs. 4 mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm B. Hohman M. D.

Nov. 15, 1920. (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 4 mos. 7 ds. In the State 51 yrs. 4 mos. 14 ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence 3032 Baker st. Balt

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Nov. 18 1920

20-UNDERTAKER Geo W Little — ADDRESS 531 Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48082 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48082

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No 2000 St Paul ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J Calhoun Gibson

(a) RESIDENCE. NO 2000 St Paul ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Not known

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Rebuta Robbin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs R. Gibson
(Address) 2000 St Paul St

15 Filed NOV 15 1920 Robert P. Harrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1920, to Nov 13, 1920, that I last saw him alive on Nov. 12, 1920, and that death occurred, on the date stated above, at 11-35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis, mitral stenosis with insufficiency. Duration of disease many years. (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of

Was there an autopsy? No Ordinary blood disease tests.

What test confirmed diagnosis? General dropsy.

(Signed) Jas. M. Craighill, M. D.

, 19 (Address) 1800 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Nov 16 1920
20 UNDERTAKER	ADDRESS
C. A. Windsfeld Jr	501 E 22 St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Should state TION is very important. See instructions on back of certificates. exact statement of OCCUPA-

D.48083 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48083

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 2805 Huntingdon Ave 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Webster

(Residence in Baltimore: No. 2805 Huntingdon Ave 20 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Feb. (Month) 16 (Day), 1863 (Year)

7-AGE 57 yrs. 8 mos. 29 ds. — If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Carroll Co Md

PARENTS.

10-NAME OF FATHER, Michael Webster

11-BIRTHPLACE OF FATHER (State or Country). Carroll Co

12-MAIDEN NAME OF MOTHER Sarah Erb.

13-BIRTHPLACE OF MOTHER (State or Country). Carroll Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Annie Webster

(Address) 2805 Huntingdon Ave

15- Filed NOV 15 1920, 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Nov (Month) 13th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Morrison M. D.
(Coroner.)

Nov 15 1920 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Ballo Cemetery	Nov 18 1920
20-UNDERTAKER	ADDRESS
A. J. Marshall	3539 Fall Rd

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

0048084 HEALTH DEPARTMENT—CITY OF BALTIMORE 0048084

8-091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Rutter ST.: 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Clark

(a) RESIDENCE. NO. 1424 Rutter ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 5-1920

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Alexander Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Marys County

12 MAIDEN NAME OF MOTHER Helen Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Helen Parker

(Address) 1424 Rutter

15 Filed NOV 16 1920 ROBERT F. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 13, 1920, to Nov 14, 1920, that I last saw her alive on Nov 13, 1920, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Wesley Straig, M. D.

11/8 19 20 (Address) 729 Eutaw Terr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	November 16 1920
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Av

INSTRUCTIONS: This certificate should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1048085 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048085

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 Mc Culloh ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel Hamilton

(Residence in Baltimore: No. 1010 Mc Culloh [redacted] yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Colored

6-DATE OF BIRTH, Unknown (Month) (Day) (Year)

7-AGE [redacted] yrs. 7 mos. 24 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 070

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith Campbell

(Address) 1010 Mc Culloh

15- NOV 16 1920 ROBERT B KRAUTER

Filed....., 191.... Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 14th, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1 1920, to Nov. 14th 1920, that I saw h[redacted] alive on Nov 10th 1920, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Senile Pneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Organic Heart Disease

(Duration) 1 yrs. mos. ds.

(Signed) A. Lee Ellis M. D.

Nov 20, 1920 (Address) 2 E Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Nov 16, 1920.

20-UNDERTAKER John H Owens — ADDRESS 5-7-9 Valley St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48086

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48086

CERTIFICATE OF DEATH.

X 45

1-PLACE OF DEATH St. Agnes Hospital Baltimore

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.: W. Lanvale WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. John B. Sweeney

(a) RESIDENCE. No. 164 S Prospect ST. Hagerstown, Md WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? 68 yrs. 0 mos. 10 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bennett Sweeney

6 DATE OF BIRTH (month, day, and year) Nov 5 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Postmaster

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer U. S. Government

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hosp Record (Address) St Agnes Hospital

15 FILED NOV 16 1920 ROBERT E KRAETER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16th 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 21 1920, to Nov 16 1920, that I last saw h(e)(r) alive on Nov 16 1920, and that death occurred, on the date stated above, at Nov 16 2.55 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma at Head of Pancreas

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Hagerstown

Did an operation precede death? yes Date of Oct 28 20

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Wm L Lang, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hagerstown Md.	11/16 1920
20 UNDERTAKER Chas F. Evans & Son	ADDRESS Mount Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Mauk.

W48087

HEALTH DEPARTMENT—CITY OF BALTIMORE

W48087

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1330 James St ST.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julius A. Mauk

(Residence in Baltimore: No. 1330 James St St.; 1 yrs. ..... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct 3 14, 1886
(Month) (Day) (Year)

7-AGE, 34 yrs. 1 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Foreman Shipyard
(b) General nature of industry, business, or establishment in which employed (or employer) U.S.G.

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Joseph Mauk

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Cruse

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph B. Lauer

(Address) 6 S. Gilmor St.

15- NOV 16 1920 ROBERT E KRAUTER

Filed....., 191.... Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 6th 1920, to Nov 14th 1920, that I saw him alive on Nov 13th 1920, and that death occurred, on the date stated above, at 1-10 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Gastric Asthenia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. L. Hammer M. D.

Nov. 16th, 1920. (Address) 1929 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL, Cathedral Cemetary

DATE OF BURIAL, Nov. 17th 1920

20-UNDERTAKER Knull & Son

ADDRESS 1729 W Pratt St

Spec.—5-19-13—M. & T.—500 Bks.

1048088 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048088

CERTIFICATE OF DEATH.

104

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Fall Road ST.; 29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Dorothy Giles

(Residence in Baltimore: No. Fall Road nr. Washington Ave St.; 1 yrs., 6 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Oct (Month) 25 (Day), 1919 (Year)

7-AGE, 1 yrs. 0 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none 086
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country), Mt Washington Md

PARENTS.

10-NAME OF FATHER, Martin R Giles

11-BIRTHPLACE OF FATHER (State or Country), Salsbury Md

12-MAIDEN NAME OF MOTHER Margaret J Keels

13-BIRTHPLACE OF MOTHER (State or Country), Mt Washington Md

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter R Giles

(Address) Mt Washington Md

15- Filed NOV 16 1920, 191.. Burial Permit Issued. ROBERT E KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 14 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 28 1920, to Nov 14 1920, that I saw h[illegible] alive on November 14 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cerebro Colitis

(Duration) 0 yrs. 0 mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Nov 15 1920 (Address) Mt Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary's Govans — DATE OF BURIAL, Nov 16.., 1920

20-UNDERTAKER Martin Fahey & Sons — ADDRESS 827 N Howard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48089

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48089

CERTIFICATE OF DEATH.

REGISTERED No. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 Miller ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Briggs

(a) RESIDENCE. No. 1628 Miller ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John R. Briggs

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 079

(b) General nature of industry, business, or establishment in which employed (or employer) general

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Waverly Va

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Christina Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Waverly Va

14 Informant John R. Briggs (Address) 1628 Miller St

15 NOV 16 1920 ROBERT E. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15, 1920

17 I HEREBY CERTIFY, That I attended deceased from 10/12, 1920, to 11/15, 1920, that I last saw her alive on Nov. 14, 1920, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Phthisis pulmonalis

(duration) yrs. 1 mos. 4 da.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) yrs. 2 mos. da.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. H. Robertson, M. D.

(Address) 1530 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Waverly Va.	Nov. 17 1920
20 UNDERTAKER	ADDRESS
Mrs J. G. Locks	1302 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48090

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48090

CERTIFICATE OF DEATH.

REGISTERED NO. 1642

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 304 N. Bond ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent O. Dean

(a) RESIDENCE. No. 304 N. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day, and year) July - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md Md

PARENTS

10 NAME OF FATHER Walter Dean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Golden Hill Md

12 MAIDEN NAME OF MOTHER Ethel King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mud Creek Md

14 Informant Walter Dean (Address) 304 N. Bond St

15 Filed NOV 16 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1920, to Nov. 14, 1920, that I last saw him alive on Nov. 14, 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. 4/7 mos. ds.

CONTRIBUTORY (Secondary) Gastritis Catarrh

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno O Robinson M. D.

19 (Address) 1532 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	Nov. 16 1920
20 UNDERTAKER	ADDRESS
Mrs J G. Locke	1302 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Mary. M Arline

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48091 HEALTH DEPARTMENT—CITY OF BALTIMORE D48091

CERTIFICATE OF DEATH. 151

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 230 S. Bethel ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Moseley Arline

(a) RESIDENCE. No. 230 S. Bethel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Oct 10th 20

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) " " 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 230 S. Bethel St Balto Md.

PARENTS

10 NAME OF FATHER Wm. Arline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bates Co N. C.

12 MAIDEN NAME OF MOTHER Mary Moseley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Wm. Arline

(Address) 230 S. Bethel St.

15 Filed NOV 16 1920 BUDDAI S TRAVIS Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 13th, 1920, to Nov 15th, 1920, that I last saw h[er] alive on " 13th, 1920, and that death occurred, on the date stated above, at 6.25 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Prematurity (7 months)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Ullman, M. D.

11/17/1920 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leakey Conn, — DATE OF BURIAL Nov 16th 1920

20 UNDERTAKER Harry A. Vodery — ADDRESS 1720 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1948092 HEALTH DEPARTMENT—CITY OF BALTIMORE 1948092

CERTIFICATE OF DEATH.

91-089

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3605 Mt. Pleasant Ave. ST.: 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret M. Becker.

(a) RESIDENCE. No. 3600 Mt Pleasant Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 29, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9.	25.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 100

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Becker

11 BIRTHPLACE OF FATHER (city or town) Bangor
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Annie Fagel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Phila Pennsylvania

14 Informant Robert Becker
(Address) 3605 Becker Ave

15 Filed NOV 16 1920 19 ROBERT P. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 19 20, to Nov 15, 19 20, that I last saw h.. alive on Nov 15, 19 20, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) I B Kelly M. D.

19 (Address) 100 N Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Nov. 16 1920
20 UNDERTAKER	ADDRESS
H. Sander & Son	1710 Fleet St

Key important. See instructions on back of certificates.

1948093 HEALTH DEPARTMENT—CITY OF BALTIMORE 1948093

CERTIFICATE OF DEATH. 155

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 4600 Harford Rd. ST. OR WARD)
2-FULL NAME Elsobed Campeggi
(Residence in Baltimore: No. 4600 Harford Rd. St.; yrs. Life mos. ds.)

REGISTERED No. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single
6-DATE OF BIRTH, May (Month) 23 (Day), 1904 (Year)
7-AGE 16 yrs. 5 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... At Home
9-BIRTHPLACE, (State or Country) Balto. Maryland
PARENTS.
10-NAME OF FATHER, Frank Campeggi
11-BIRTHPLACE OF FATHER (State or Country) Italy
12-MAIDEN NAME OF MOTHER Elizabeth Otis
13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank Campeggi
(Address) Hamilton Md.

15- NOV 16 1920 Filed....., 191.... ROBERT B KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 13 (Day), 1920 (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Suicide.
by bullet wound.
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) A. K. Ingles M. D.
(Coroner)
11-16 1920 (Address) 3 E. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery — DATE OF BURIAL, Nov. 16, 1920
20-UNDERTAKER Brett Lassahn & Sons — ADDRESS Fullerton Md.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D48094 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D48094

Charcoal Club

CERTIFICATE OF DEATH.

REGISTERED No. C 170

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ~~Bable & Lay~~ S W Cor St Paul + Preston St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Malone

(Residence in Baltimore: No. 3822 Greenmount St.; yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Sgle

6-DATE OF BIRTH, Feb. 8th (Month) (Day), 1889 (Year)

7-AGE, 31 yrs. 9 mos. 6 da. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Book Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): 004

9-BIRTHPLACE. (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Dan. Malone

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Margaret Regan

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. Malone

(Address) 3822 Greenmount

15- Filed NOV 18 1920, 191.... ROBERT B KRAUTER Registrar. Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 14 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Nephritis

Uremia (Duration) .....yrs.....mos.....da.

CONTRIBUTORY (Secondary) Probably Convulsions (Duration) .....yrs.....mos.....da.

(Signed) W. J. Riley M. D. (Coroner.)

Nov. 16, 1920 (Address) 1032 Berry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS),
At place of death .....yrs.....mos.....da. In the State .....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cemetery	Nov. 17, 1920
20-UNDERTAKER Lilly + Zeiler	ADDRESS 408 S. Wolfe St.

A. B. C.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48095

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48095

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 W Balto St ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva E Hammond

(a) RESIDENCE. No. 921 W Balto ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. 11 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Hammond

6 DATE OF BIRTH (month, day, and year) Nov 30th 1875

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
44	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo Lange

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Cora Tiffick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Wm Hammond

(Address) 921 W Balto St

15 Filed ..... 19 ..... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1920

17 I HEREBY CERTIFY, That I attended deceased from 11, 12, 1920, to 11, 15, 1920, that I last saw h[er] alive on 11, 15, 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) Johns. Hopkins, M. D.

11/16 1920 (Address) 888 N Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem - Brooklyn	Nov 19th 1920
20 UNDERTAKER John J Cowan & Son	ADDRESS 901 Hollins St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48096

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48096

CERTIFICATE OF DEATH.

REGISTERED NO. C 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 745 George ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dandelion Buchannon

(Residence in Baltimore: No. 745 George St.; 40 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, Negro

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ? (Month) ? (Day) 1861 (Year)

7-AGE, 59 yrs. ? mos. ? da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, William Bush

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country), —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lula Williams

(Address) 745 George St

15- NOV 16 1920

Filed ..... 1920., 191.. ROBERT B KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 10, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 10 1920, to Nov 10 1920, that I saw her alive on Nov 10 1920, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease (mitral insufficiency)

(Duration) yrs. 10 mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J D McRae M. D.

11-16, 1920 (Address) 739 George St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem | DATE OF BURIAL, Nov 16, 1920

20-UNDERTAKER George H Holland | ADDRESS 1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48097

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48097

104

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 5 WARD)

2-FULL NAME Wm Mitchell.

(a) RESIDENCE. NO. 216 Calvin St. Baltimore Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) June 22-'20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child yrs

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) md.

PARENTS

10 NAME OF FATHER Arsie Gaddy.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Fodie Mitchell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant Father.
(Address)

15 Filed NOV 16 1920 ROBERT E LEAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 11 , 1920, to Nov 15 , 1920, that I last saw him alive on Nov 15 , 1920, and that death occurred, on the date stated above, at 7 30 a. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown address

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? None

(Signed) W. H. Davison, M. D.

, 19 (Address) J H H Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery	Nov 16 19 20

20 UNDERTAKER Mrs Robert Elliott ADDRESS 720 Ashland Ave

CAUSE OF DEATH in plain terms. Abbreviations should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates. may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-48098 HEALTH DEPARTMENT—CITY OF BALTIMORE D48098

CERTIFICATE OF DEATH. 120

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2210 Brunt ST. 14 WARD)

2-FULL NAME Hannibal Lee

(a) RESIDENCE. NO. 2210 Brunt ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? 70 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Jennie Lee

6 DATE OF BIRTH (month, day, and year) ? 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Jesse Lee

11 BIRTHPLACE OF FATHER (city or town)..... (State or country) Md.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)..... (State or country)

14 Informant Frances Fitzhugh (Address) 1522 Druid Hill Ave

15 Filed NOV 16 1920 19 ROBERT B KRAUTER Registrar

Burial Permit Other

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1920, to Nov 15, 1920, that I last saw him alive on Nov. 12, 1920, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E William Frey M. D.

11/15, 1920 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Nat'l	16 1920

20 UNDERTAKER JAMES H. DENNIS

ADDRESS 1303 PRESTMAN ST.

Spec.—8-24-14—M. & T.—2000 Bks.

1948099

HEALTH DEPARTMENT—CITY OF BALTIMORE

1948099

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C 64

CITY OF BALTIMORE: (No. 1816 Division ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Whitney

(Residence in Baltimore: No. 1816 Division St.; 31 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, November, 1871
(Month) (Day) (Year)

7-AGE 49 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) Private Family

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thomas Teighman

11-BIRTHPLACE OF FATHER (State or Country), not known

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaac Tasker

(Address) 1816 Division St.

NOV 16 1920 ROBERT E KRAUTER

Filed ..... 191.. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 13th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 11th 1920, to November 13 1920, that I saw h er alive on November 13 1920, and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Lesion

(Duration) yrs. mos. ds.

(Signed) Harry F. Brown M. D.

Nov 15, 191.. (Address) 15 E Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Nov 16th 1920

20-UNDERTAKER Samuel T Bensley

ADDRESS 578 Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1048100

HEALTH DEPARTMENT--CITY OF BALTIMORE

1048100

CERTIFICATE OF DEATH

151

REGISTERED NO. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1215 S. Clinton ST.: 26 (OR WARD)

2-FULL NAME William Crandell

(Residence in Baltimore: No. 1215 S. Clinton St.: 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6-DATE OF BIRTH Nov 15, 1920 (Month) (Day) (Year)

7-AGE ..... yrs. ..... mos. ..... ds. If LESS than 1 day, 2 hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work 000
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country) Baltimore

PARENTS

10-NAME OF FATHER William Crandell

11-BIRTHPLACE OF FATHER (State or country) Drals, Md.

12-MAIDEN NAME OF MOTHER Mary Varlita

13-BIRTHPLACE OF MOTHER (State or country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Crandell

(Address) 1215 S. Clinton

NOV 16 1920 Filed ..... 191 ROBERT E KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Nov. 16, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1920, to, Nov 16 1920, that I saw h[illegible] alive on Nov 15, 1920, and that death occurred, on the date stated above, at 1.20 A m.

The CAUSE OF DEATH* was as follows:

Congenital weakness, Premature birth

..... (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed), Henry M. Browne M. D.

Nov 16, 1920 (Address) 519 Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL St. Stanislaus Cem. DATE OF BURIAL Nov. 16 191 20

20-UNDERTAKER Stephen F. Kralkowski ADDRESS 1500 Kenwood

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48101 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48101

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1731 Ellamont Ave 15 42 REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie M. Schanze

(a) RESIDENCE. No. 1900 W. North ave. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of Albert Schanze

6 DATE OF BIRTH (month, day, and year) Nov. 10 1872.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48.		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. H. Marley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Dr. Fred. Schanze.
(Address) 1602 W. North Ave

15 Filed NOV 18 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-14 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug. 13. 1920. to Nov. 14. 1920. that I last saw her alive on Nov. 14. 1920. and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Left Ovary with Metastasis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at 1900 W. North Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Malignancy

(Signed) R. C. Metzel M. D.

Nov. 15 1920 (Address) 1403 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leuden Park Cem.	Nov. 17 1920
20 UNDERTAKER	ADDRESS
Josiah Syfer	1600 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D.48102

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48102

CERTIFICATE OF DEATH.

138

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2621 Kate av ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Louise Vetter

(a) RESIDENCE. NO. 2621 Kate av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herbert F Vetter

6 DATE OF BIRTH (month, day, and year): May 31 1897

7 AGE — Years: 23 — Months: 5 — Days: 15 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: n

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Fredrick Thiele

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Minnie Hofmeister

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Herbert F Vetter
(Address): 2621 Kate av.

15 Filed NOV 16 1920 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 12 1920 to Nov 15 1920

that I last saw h[illegible] alive on Nov 15 1920

and that death occurred, on the date stated above, at 5.40 a. m.

The CAUSE OF DEATH* was as follows:

1137

Uremic Convulsions

Acute Nephritis

(duration) .... yrs. .... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John D Bubert M. D.

11/15 1920 (Address) 1854 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Nov 18 19 2[illegible]

20 UNDERTAKER: Louis Heemann — ADDRESS: 326 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Should state TION is very important. See instructions on back of certificates. Statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.48103 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.48103

CERTIFICATE OF DEATH. 104

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2128 W. Mulberry St.: 20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George V. Wills Jr.

(a) RESIDENCE. No. 2128 W. Mulberry St., Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Oct. 30, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George V. Wills

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Barbara Bergman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant George V. Wills
(Address) 2128 W. Mulberry Street

15 Filed NOV 16 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11- 15- 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1920, to Nov. 15, 1920, that I last saw h... alive on Nov. 15, 1920, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) ....yrs. ....mos. 2½ ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Samuel Brandt, M. D.

, 19 (Address) 2301 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	11/ 17, 1920
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48104

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48104

28

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2524 McHenry St ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Gilbert

(a) RESIDENCE. No. 2524 McHenry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 2 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Denton Gilbert

6 DATE OF BIRTH (month, day, and year) Aug 24 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 027

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Conrad Hoelbrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Eliz. Deems

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Denton W. Gilbert
(Address) 2524 McHenry St

15 Filed NOV 16 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 3- 1919. to Nov. 14, 1920.

that I last saw her alive on Nov 14, 1920

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs.

Chronic (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Exam

(Signed) C. Eichenbrick, M. D.

, 19 (Address) 1412 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Nov 17 '20
20 UNDERTAKER	ADDRESS
Wm J Tuckey & Sons	Norfolk Va

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48105 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48105

CERTIFICATE OF DEATH. 37

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 Sterling ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Harding Walker

(a) RESIDENCE. NO. 701 Sterling ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	B	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 11/9/20

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm. Walker

11 BIRTHPLACE OF FATHER (city or town) Motley (State or country) Va

12 MAIDEN NAME OF MOTHER Midda Drake

13 BIRTHPLACE OF MOTHER (city or town) N.C. (State or country)

14 Informant Wm Walker
(Address) 701 Sterling St

15 Filed . 19 Robert P. Harrison, Registrar

NOV 16 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1920, to Nov 14, 1920, that I last saw him alive on Nov 13, 1920, and that death occurred, on the date stated above, at 3.9. m.

The CAUSE OF DEATH* was as follows:

Congenital Lues

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Scaly hands & feet Lemorhage

(Signed) G. E. Hoornstein, M. D.

11/15, 1920 (Address) 733 Airquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health.

Per. Wm. E. WOODALL

NOV 15 1920

MARKS must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.48106

HEALTH DEPARTMENT---CITY OF BALTIMORE

D.48106

151

CERTIFICATE OF DEATH

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 N. Appleton ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Newell (1st Twin)

(Residence in Baltimore: No. 916 N. Appleton St.; ~ yrs. ~ mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: M

4-COLOR OR RACE: W

5-SINGLE ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)

6-DATE OF BIRTH: Nov (Month) 15 (Day), 1920 (Year)

7-AGE ..... yrs. ..... mos. ..... ds. If LESS than 1 day, — hrs., or 3 min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE (State or country) Balto Md

PARENTS

10-NAME OF FATHER Harry Newell

11-BIRTHPLACE OF FATHER (State or country) Balto Md

12-MAIDEN NAME OF MOTHER Ada Martha Holden

13-BIRTHPLACE OF MOTHER (State or country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred H Newell

(Address) 916 N. Appleton St

15- Robert P. Harrison, JOHNS

Filed ..... 191 ..... Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Nov (Month) 15 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....., 191....., to, ..., 191.....,

that I saw h..... alive on ....., 191.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed), Fred Talbott M. D.

Nov 16 1920 [Address] 1352 W. North

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL ..... 191 ....

20-UNDERTAKER Commissioner Health,

Per Wm. E. WOODALL

ADDRESS NOV 15 1920

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PERSONS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.48107

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

151 D.48107

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 N Appleton ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Newell (2 nd Twin)

(Residence in Baltimore: No. 916 N. Appleton St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: M.

4-COLOR OR RACE: W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6-DATE OF BIRTH: Nov (Month) 15 (Day), 1920 (Year)

7-AGE: — yrs. — mos. — ds. If LESS than 1 day, — hrs., or 3 min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work — Ood
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE (State or country) Balto Md

PARENTS

10-NAME OF FATHER Frank Harry Newell

11-BIRTHPLACE OF FATHER (State or country) Balto Md

12-MAIDEN NAME OF MOTHER Ida Martha Holden

13-BIRTHPLACE OF MOTHER (State or country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank H. Newell

(Address) 916 N. Appleton St

15- Filed NOV 18 1920 191 Robert P. Harrison, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov (Month) 15 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....., 191..., to, ..., 191...,
that I saw h... alive on ....., 191...,
and that death occurred, on the date stated above, at ....m.
The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ....yrs ....mos ....ds.

Contributory (SECONDARY)

(Duration) ....yrs ....mos ....ds.

(Signed) Edw Talbott M. D.

Nov 15 1920 [Address] 1353 W Hatton

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ....yrs ....mos ....ds. In the State ....yrs ....mos ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL ....., 191...

20-UNDERTAKER: Commissioner Health — ADDRESS

per Wm E. WOODALL NOV 15 1920

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48108 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48108

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 Hanover ST. 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wallace Hooper

(a) RESIDENCE. No. 520 Hanover ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Belle Ward Hooper

6 DATE OF BIRTH (month, day, and year) July 17 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) Anne Arundel Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Cap't Wm. Hooper

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Prout

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Belle Ward Hooper
(Address) 520 Hanover St.

15 NOV 18 1920 Robert P. Harrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1920, to Nov 15, 1920, that I last saw him alive on Nov 14, 1920, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. H. Smith, M. D.

, 19 (Address) 109 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK	NOV 17 1920

20 UNDERTAKER	ADDRESS
JOHN F. DENNY	715 LIGHT ST.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48109

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48109

CERTIFICATE OF DEATH.

X 146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Emil Hosp ST.: 11 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Mc Kinn

(a) RESIDENCE. No. 518 E. St. Sparrows Pt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor at Ø

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem steel Co

(c) Name of employer Sparrows Point Md

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Thos E. McKinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jessie F Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Eugene McKinn

(Address) Box at Sparrows Pt Md

15 Filed NOV 16 1920 19 Robert P. Harrison, Registrar

Burial Permit ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1920

17 I HEREBY CERTIFY, That I attended deceased from October 17, 1920, to November 15, 1920, that I last saw him alive on November 15, 1920, and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows: OVER

Septicemia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Osteomyelitis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Manifestations

(Signed) Richardson, M. D.

, 19 (Address) Md Emil Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rhoadesville Va	Nov 17 1920
20 UNDERTAKER	ADDRESS
John F Denny	710 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48110 ✓D.48110

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Gibson McGill.

(a) RESIDENCE. No. 1803 Braddish Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. 17 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
BUSBAND of ~~(or) WIFE of~~ Kathleen McGill

6 DATE OF BIRTH (month, day, and year) Oct. 27 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28 years.	—	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 631

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER George Gill

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Margaret C. Kolberg

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant George Gill
(Address) 124 E. Montgomery St.

15 Filed NOV 18 1920 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 15 1920

17 I HEREBY CERTIFY, That I attended deceased from October 16, 1920, to November 15, 1920, that I last saw him alive on November 15, 1920, and that death occurred, on the date stated above, at 4:00 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory & Clinical findings

(Signed) C. Wilbur Stewart, M. D.

11/15, 1920 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Goodlawn Cemetery	NOV 18 1920
20 UNDERTAKER JOHN F. DENNY	ADDRESS 715 LIGHT ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Should state TION is very important. See instructions on back of certificates. exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48111 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48111

CERTIFICATE OF DEATH.

64

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 754 Ramsay ST. 21 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Rudolph Wilkinson

(a) RESIDENCE. No. 754 Ramsay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida L. Wilkinson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Wilkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Charlotte Mullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Ida L. Wilkinson
(Address) 754 Ramsay

15 Filed NOV 16 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 14 1920

17 I HEREBY CERTIFY, That I attended deceased from NOV 14, 1920, to NOV 14, 1920, that I last saw him alive on NOV. 14, 1920, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Stone Creek

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) J. Mosby Strong, M. D.

(Address) 29 E. Eutaw ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 20 19
20 UNDERTAKER Joseph L. B. Cook	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Ems.

D. 48112

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48112

CERTIFICATE OF DEATH.

108

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. St. Agnes Hospital St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. John L. Towson, Jr.

(a) RESIDENCE. No. 1820 W. Lafayette Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	M

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Mrs. Jennie Towson

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agt

(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer not known

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Towson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary E. Purson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore " Md.

14 Informant Mrs. L. Towson

(Address) 1820 W. Lafayette Ave.

15 Filed NOV 16 1920 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1920, to Nov. 15, 1920

that I last saw him alive on Nov. 15, 1920

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Appendicitis & Peritonitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-15-20

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. W. Wearg, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov. 18, 1920
20 UNDERTAKER George J. Field	ADDRESS 1060 W. Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state Exact Street and No. of OCCUPATION is very important. See instructions on back of certificates.

1048113. ... BALTIMORE 1048113

CERTIFICATE OF DEATH.

151

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4905 York Rd ST.: ... 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Taylor

(Residence in Baltimore: No. 4905 York Rd St.: 0 yrs., 0 mos. 0 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, November 14, 1920
(Month) (Day) (Year)

7-AGE, ... yrs. ... mos. ... ds. If LESS than 1 day, 6 hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓ 000
(b) General nature of industry, business, or establishment in which employed (or employer) ✓

9-BIRTHPLACE, (State or Country), 4905 York Rd.

PARENTS.

10-NAME OF FATHER, Lloyd Taylor

11-BIRTHPLACE OF FATHER (State or Country), Preston, Md

12-MAIDEN NAME OF MOTHER Emma Conway

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lloyd Taylor

(Address) 4905 York Rd

15- NOV 17 1920 ROBERT E KRAUTH

Burial Permit Issued by ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 14, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 14 1920, to Nov 14 1920, that I saw him alive on Nov 14 1920, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth 5 Months fetus

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Mother full term Twin

Nov 12 1920 (Duration) ... yrs. ... mos. ... ds.

(Signed) G. W. T. Bond M. D.

Nov 14, 1920 (Address) 611 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death? Obstetrics

Former or usual residence Same.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner of Health

NOV 15 1920

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48114

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48114

120

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 E. Chase ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph J. Gaeng

(a) RESIDENCE No. 1513 E Chase ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) ~~WIFE~~ of Margaret M Gaeng

6 DATE OF BIRTH (month, day, and year) Oct. 30 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

080

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Michael J. Gaeng

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gertrude Schilling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Margaret M. Gaeng

(Address) 1513 E Chase St

15 Filed NOV 17 1920 ROBERT B. KRAUTER Registrar

Burial Permit Obtd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 15 1920

17 I HEREBY CERTIFY, That I attended deceased from September 1st 1920, to November 15th 1920

that I last saw him alive on November 15th 1920

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Renal Interstitial Nephritis

Uraemic Convulsions (duration) yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Charles A. A. Meyer M. D.

11/15 1920 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov. 18 1920
20 UNDERTAKER Henry Hoeck Son	ADDRESS 1301 E Eager

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48118 HEALTH DEPARTMENT—CITY OF BALTIMORE D48118

28

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 N Carlton ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Taylor

(a) RESIDENCE. NO. 106 N Carlton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 13 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23.		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Alfred Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rie Taylor (Address) 106 N Carlton St

15 NOV 17 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1920, to Nov 16, 1920, that I last saw h & alive on Nov 13, 1920, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Pthisis Pulmonalis

(duration) yrs. 1 7/1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) H. S. McCard M. D.

11/16, 1920 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Nov 18 20
20 UNDERTAKER	ADDRESS 1140
Brown & Freeland.	Schroder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1948116

HEALTH DEPARTMENT—CITY OF BALTIMORE

1948116

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 Maccubbin ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Nichols

(a) RESIDENCE. NO. 1721 Maccubbin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Clarence Nicholls

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ida Barnetta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Ida Nichols

(Address) 1721 Maccubbin

15 Filed NOV 17 1920 ROBERT E KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14, 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1920, to Nov. 14, 1920, that I last saw him alive on Nov. 14, 1920, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Carey J. Green, M. D.

11-15, 1920 (Address) 1209½ Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery. Nov. 17	1920
20 UNDERTAKER	ADDRESS
Milton. Davis.	413 N Eden St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-24—H. P. Co.—1000 Bks.

10484 17 — 10484 17

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 51

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: 19 Ward) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Link

(a) RESIDENCE. No. Lenoir, N. C. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced. HUSBAND of (or) WIFE of Annie Link

6 DATE OF BIRTH (month, day, and year) Dec 10-1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	11	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory 186

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Father Link

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Both. Sudderth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Hospital Record (Address) J. H. H.

15 Filed NOV 17 1920 ROBERT B. LEAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 5th 1920, to Nov 15th 1920, that I last saw him alive on Nov 15th 1920, and that death occurred, on the date stated above, at 12:50 P.M.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goiter

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Hegatius Inferior Thyroid Vessels

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Nov. 15, 1920

Was there an autopsy? Yes.

What test confirmed diagnosis? Study of Thyroid Gland

(Signed) Grant R. S. Reid, M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Morganton NC	Nov 17 1920

20 UNDERTAKER John O. Mitchell ADDRESS 131 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1048118 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048118

CERTIFICATE OF DEATH.

64

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 115 Winter St. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Jane Anderson. (C)

(Residence in Baltimore: No. 115 Winter St. St.: 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female.	Colored.	Widow.

6-DATE OF BIRTH, Do not know. (Month) (Day) 1 (Year)

7-AGE, 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None. 000
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Pittsburg, Pa.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER Do not know.

13-BIRTHPLACE OF MOTHER (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eleanor Roberts. (C) daughter.

(Address) 115 Winter St.

15- Filed NOV 17 1920 191 ROBERT B KRAUTER Registrar. Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 14th. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) E. C. Emmanuel M. D. (Coroner.)

Nov. 15, 1920 (Address) 12 W. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Nov. 17 1920

20-UNDERTAKER Arnold & Hendley ADDRESS 375 W. Lee

CAUSE OF DEATH information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48119

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48119

CERTIFICATE OF DEATH.

151

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 308 S. Chappel ST.; W WARD)

2-FULL NAME Bernard Anthony Griffith

(a) RESIDENCE. No. 508 S. Chappel ST., 21 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 5, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer) infant

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas B. Griffith

11 BIRTHPLACE OF FATHER (city or town) Denton
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida Cecginia

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Thos B. Griffith
(Address) 508 S. Chappel St.

15 Filed NOV 17 1920 19 ROBERT J. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1920, to Nov 15, 1920, that I last saw him alive on Nov 15, 1920, and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion - stomatitis -
general inanition
(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Premature birth - 7th mth.
Pemphigus (duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

Nov 16 1920 (Address) 3048 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov 17 1920
20 UNDERTAKER Wm Galloway	ADDRESS 1618 Ea

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

2048120 HEALTH DEPARTMENT—CITY OF BALTIMORE 2048120

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2704 Orleans ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith Adele Kerr

(Residence in Baltimore: No. 2704 Orleans St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
female	white	single

6-DATE OF BIRTH, Mar 23, 1 (Month) (Day) (Year)

7-AGE, 2 yrs. 7 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER. Edw F Kerr

11-BIRTHPLACE OF FATHER (State or Country). Rock Hall Md

12-MAIDEN NAME OF MOTHER Edith Blackiston

13-BIRTHPLACE OF MOTHER (State or Country). Rock Hall Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edw F Kerr
(Address) 2704 Orleans St

15- Filed NOV 17 1920, 191... ROBERT B KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 16, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 1920, to Nov 16 1920, that I saw h[illegible] alive on Nov 16 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

(a) Bronchopneumonia

.....

.....

(Duration) .....yrs. .....mos. 7 ds.

CONTRIBUTORY .....
(Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.

11.17., 1920. (Address) 2400 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Rock Hall Md	11 18, 191...

20-UNDERTAKER John Herwig & Co ADDRESS 2008 Orlean

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

048121 HEALTH DEPARTMENT—CITY OF BALTIMORE 048121

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 Myrtle Ave ST.; 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Burton

(Residence in Baltimore: No. 425 Myrtle Ave. St.; 20 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Fem.	Col	Widow

6-DATE OF BIRTH, Apr. 4, 1882
(Month) (Day) (Year)

7-AGE, 38 yrs. 7 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER Not known

11-BIRTHPLACE OF FATHER (State or Country) Not known

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country) Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Easton

(Address) 916 Eden ave

15-

Filed ....., 191.....
Registrar.

NOV 17 1920
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 14, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 9 1919, to Nov. 13 1920, that I saw h[illegible] alive on Nov. 13 1920, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Ulcerated Cancer
(Secondary)

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY Exhaustion
(Secondary)

(Duration) yrs. mos. 3 ds.

(Signed) Dana Waggner M. D.

Nov. 16, 1920 (Address) 1706 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Browns Wolf Md	Nov 17, 1920
20-UNDERTAKER Daniel Easton	ADDRESS 916 Eden ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1044230 1048122

HEALTH DEPARTMENT—CITY OF BALTIMORE 1048122

CERTIFICATE OF DEATH.

64-091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.: 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Johns.

(a) RESIDENCE. No. 13 Midvale Road St., Roland Park Md Ward.

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1 - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) ?
(State or country)

PARENTS

10 NAME OF FATHER Hector Bowser

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant J.T.T.
(Address)

15 Filed NOV 17 1920 ROBERT P. FRAZIER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 - 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 5. ....., 1920, to Nov 14 ....., 1920,

that I last saw her alive on Nov. 14 ....., 1920,

and that death occurred, on the date stated above, at 1.40 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(duration) yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. ..... mos. 2 ds.

18 Where was disease contrarted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) L. R. Mason M. D.

....., 19 ..... (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 17 20
20 UNDERTAKER David Taylor	ADDRESS 916 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

1048123

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048123

151

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 Pierce ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Johnson

(a) RESIDENCE. No. 820 Pierce ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 10-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore ? Maryland

10 NAME OF FATHER Geo. Henry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bologne Middlesex Co. Virginia

12 MAIDEN NAME OF MOTHER Beatrice Garnet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Elson Virginia.

PARENTS

14 Informant Lillean Davenport. (Address) 820 Pierce St.

15 Filed NOV 17 1920 ROLFE, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1920, to Nov. 15, 1920, that I last saw her alive on Nov. 15 1920 and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity.
(Thirty two weeks foetus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Morris Fox, M. D.

11/16, 1920 Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 17 1920
20 UNDERTAKER	ADDRESS
David Easton	916 Pennsylvania

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Frances Szmydt

048124 HEALTH DEPARTMENT—CITY OF BALTIMORE 048124

CERTIFICATE OF DEATH.

64

1 PLACE OF DEATH
CITY OF BALTIMORE (No. Alleanna & Chester ST.: V WARD)
REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Szmydt
(Residence in Baltimore: No. Alleanna & Chester ST.; 38 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 1868 (Year)

7-AGE, 52 yrs. mos. ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work and
(b) General nature of industry, business, or establishment in which employed (or employer): Fruit-Packing House.

9-BIRTHPLACE, (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, — Werner.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Michael Szmydt Son.
(Address) 513 S. Washington St.

15- NOV 17 1920
Filed....., 191.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Nov 16 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) A. J. Smaltz M. D.
(Coroner)
Nov 17, 1920 (Address) 1004 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus. DATE OF BURIAL, Nov 19th, 1920.
20-UNDERTAKER M. F. Sulowski. ADDRESS 705 S. Ann St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Adam Drosd.

D48125 HEALTH DEPARTMENT—CITY OF BALTIMORE D48125

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 729 S Broadway ST.: 1 WARD)

REGISTERED No. C....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam Drosd

(Residence in Baltimore: No. 729 S Broadway St.; yrs., 12 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Nov 16th, 1920 (Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 12 hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.... 000
(b) General nature of industry, business, or establishment in which employed (or employer).... Infant.

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Andrew Drosd.

11-BIRTHPLACE OF FATHER (State or Country). Poland.

12-MAIDEN NAME OF MOTHER Stefana Rekik

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Drosd.

(Address) 729 S. Broadway.

15- Filed NOV 17 1920 19.... ROBERT B KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Nov 17, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Medigator (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Congenital Debility

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) Thos Ryan Forsythe M. D. (Coroner.)

Nov 17, 1920 (Address) 1000 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary,	Nov 17, 1920
20-UNDERTAKER M F. Sadowski,	ADDRESS 905 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D48126

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48126

CERTIFICATE OF DEATH.

5 X 166

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1345 High Alley - St.; 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joe Hill (Fatchett)

(Residence in Baltimore: No. 1345 High Alley.

St.: yrs., 1 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word) Married

6-DATE OF BIRTH, ... (Month) ..... (Day), 1889 (Year)

7-AGE, 31 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): O'Donnell

9-BIRTHPLACE, (State or Country), Richmond, Va

PARENTS.

10-NAME OF FATHER, C. Hill

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER, Emma Turner

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Hill

(Address) 626 S. Charles St

15- NOV 17 1920 ROBERT F KRAUTER

1920 ..... 191.... Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 13, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Autopsy
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation Burns (Fire)
Smoke -
(Duration) ..... yrs. ..... mos. — ds.

CONTRIBUTORY (Secondary) Shock
(Duration) ..... yrs. ..... mos. — ds.

(Signed) H. C. Wade M. D.
(Coroner.)
11/17/20, 191... (Address) 1432 E. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Richmond Va

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Nov. 17, 1920

20-UNDERTAKER Jno H. Toadvine — ADDRESS 142 W. Niedt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48127 HEALTH DEPARTMENT—CITY OF BALTIMORE D48127

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1031 Baldwin ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Colon Clinton Carlisle

(a) RESIDENCE. No. 1031 Baldwin ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Kate Rodgers (Carlisle)

6 DATE OF BIRTH (month, day, and year) 12/18/85

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ordinary Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Fry Pitcairn 086

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Richard J. Carlisle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del

12 MAIDEN NAME OF MOTHER Mary I. Hinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Kate Carlisle (Address) 1031 Baldwin St.

15 Filed NOV 17 1920 19 ROBERT B. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/14/20 19

17 I HEREBY CERTIFY, That I attended deceased from 11/2/20, 19, to 11/14/20, 19,

that I last saw h— alive on 11/14/20, 19,

and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Lung Sarcoma

Malig (duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Nov 1 1920

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Ex.

(Signed) Bernard J. Fury, M. D.

11/16, 1920 (Address) 910 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Eastern Cem	11/17 1920
20 UNDERTAKER	ADDRESS
Robt J. Fahey & Sons	318 Light St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Spec.—8-24-14—M. & T.—2000 Bks.

over. C affidavit

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48128

CERTIFICATE OF DEATH.

1202 D48128

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 N Belnord ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Schachner

(Residence in Baltimore: No. 714 N Belnord Lane St.; 40 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	White	Married

6-DATE OF BIRTH. January 16 (Month) (Day) 1850 (Year)

7-AGE. 69 yrs. 10 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer 086
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. dont Know

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER (State or Country). Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Claudia Schachner

(Address) 714 N. Belnord ave

15-

Filed NOV 17 1920 ROBERT B KRAUTH Registrar.

Burial Permit 01671

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 16, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 2 1920, to November 11 1920, that I saw him alive on 11 November 1920, and that death occurred, on the date stated above, at 4 1/2 p. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Heart

Complicated with Arterio Sclerosis (Duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary)

d. (Duration) yrs. mos. ds.

(Signed) Thomas J Simon M. D.

November 16 1920. (Address) 1025 N. Wolfe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Nov 19, 1920
20-UNDERTAKER	ADDRESS
William Cook	502 E North Ave

Exact statement of OCCUPATION is very important. See instructions on back of certificate. Be sure to write in plain terms, so that it may be properly classified.

NOV 20 1920

Nov. 19/20

This Certifies that there
was an Error in the age of
Mr. Frederick Schafner who Died
on 16th inst at 714 N Broadway
the Proper age being 69 years

11/19/20

Thos. J. Simmons M.D.
Thos N Walper

DATE
NAME
ADDRESS

2115139 HEALTH DEPARTMENT—CITY OF BALTIMORE

D48129 HEALTH DEPARTMENT—CITY OF BALTIMORE

103 D 48129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1120 Balkan St.

CITY OF BALTIMORE (No. ~~Leah Alston~~ St.: 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leah Alston

(Residence in Baltimore: No. 1120 Balkan St. St.(yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	married

6-DATE OF BIRTH, June (Month), (Day) 1865 (Year)

7-AGE,	If LESS than 1 day,
55 yrs. 5 mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): 041

9-BIRTHPLACE, (State or Country), S. Carolina.

PARENTS.

10-NAME OF FATHER, Randolph Ruffin

11-BIRTHPLACE OF FATHER (State or Country), S. Carolina.

12-MAIDEN NAME OF MOTHER Cynthia Timmons

13-BIRTHPLACE OF MOTHER (State or Country), S. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josephine Scott

(Address) 2719 (A) Sherman Ave, N.W. Wash D.C.

15- Filed NOV 17 1920 ROBERT B KRAUTER Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 15 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

1 hr. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion 4 hrs.

(Duration) yrs. mos. ds.

(Signed) J. F. Hennessy M. D. (Coroner.)

Nov. 16, 1920 (Address) 2802 Edmondson Ave,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel	Nov. 18, 1920

20-UNDERTAKER	ADDRESS
William Cook	5025 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48130

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48130

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Orrie M. Dryden

(a) RESIDENCE. No. 326 High st. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt.	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER T. J. Dryden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address) M.C.H.

15 NOV 17 1920 ROBERT B LEROTH Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16, 1920

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1920, to Nov. 16, 1920, that I last saw him alive on Nov. 16, 1920, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 14 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. J. Tigrey, M. D.

11-16-20, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Hill Cemetery Baltimore Md	Nov 19 1920
20 UNDERTAKER William Cook	ADDRESS 502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Blks.

D 48131

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48131

CERTIFICATE OF DEATH.

1042

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2212 Etting ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Purnell Brooks

(Residence in Baltimore: No. 2212 Etting St.; St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH. Aug. 30, 1920
(Month) (Day) (Year)

7-AGE. yrs. 2 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country), Baltimore, md.

PARENTS.

10-NAME OF FATHER, Hezekiah Ogle Shipley

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Mamie Brooks

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Brooks

(Address) 2212 Etting St.

15- Filed NOV 17 1920, 191.... ROBERT B KRAUTER Registrar.

NOV 17 1920
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 15th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 4 1920, to Nov 15 1920, that I saw h[illegible] alive on Nov 13 1920, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Clio Colitis

(Duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. L. Joslin M. D.

Nov. 16., 1920 (Address) 33 W. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Zion	Nov. 17., 1920
20-UNDERTAKER	ADDRESS
JAMES H. DENNIS	1303 PRESTMAN ST.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48132 HEALTH DEPARTMENT—CITY OF BALTIMORE D48132

91

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 E Lombard ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Dimat

(a) RESIDENCE. No. 1531 E Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 21 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7		

8 OCCUPATION OF DECEASED Infant 000

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Michael Dimat

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Mary Shimowitz

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Michael Dimat (Address) 1531 E Lombard

15 Filed NOV 17 1920 19 ERNEST B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1920, to Nov 16, 1920, that I last saw h— alive on Nov 16, 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. Wheaton, M. D.

(Address) 1 E Read

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Edmondson Primety

DATE OF BURIAL: Nov 17 1920

20 UNDERTAKER: Wendell Diffenderffer Son

ADDRESS: 37 S Amm

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48133

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48133

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. St.: 5 Ward) 79 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Turner

(a) RESIDENCE. No. 1115 E. Monument St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Apr. 14, 1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49 ~~yr~~	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 070

(b) General nature of industry, business, or establishment in which employed (or employer) Janitor

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Abraham Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sarah Lewis
(Address) 1115 E Monument St

NOV 17 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/16 1920

17 I HEREBY CERTIFY, That I attended deceased from 11/1 1920, to 11/16 1920, that I last saw h— alive on 11/16 1920, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Laryngitis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Lewis A. Ridgely, M. D.

11/16, 1920 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Nov 17 1920
20 UNDERTAKER	ADDRESS
Mrs Robt Arliott	Ashland Ave

CAUSE OF DEATH in plain terms, so that it should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates. that it may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

1948134

HEALTH DEPARTMENT—CITY OF BALTIMORE

1948134

CERTIFICATE OF DEATH.

79

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2529 W. Balto ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary V. Zoeller

(a) RESIDENCE. NO. 2529 W Balto ST., WARD. 21st

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Valentine Zoeller

6 DATE OF BIRTH (month, day, and year) Nov 3 - 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Streckfus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary A. Hoboken

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary C. Feehley

(Address) 2529 W. Balto st

15 NOV 17 1920 ROBERT B. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 10th, 1920, to Nov 17th, 1920, that I last saw her alive on Nov 17th, 1920, and that death occurred, on the date stated above, at 5.15 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Adolescence

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W Garrison Harlos M. D.

(Address) 3015 Presbury st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mem Cathedral Cem.	Nov-20 1920
20 UNDERTAKER	ADDRESS
F. W. Trautwein	1837 Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48135 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48135

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 850 Mangold ST.; 21 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irene K Koch

(Residence in Baltimore: No. 850 Mangold St. Lipo rs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, April (Month) 16 (Day), 1893 (Year)

7-AGE,	If LESS than 1 day,
27 yrs. 7 mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Robt. J. Cooke

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary E. Arbuthnot

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt. J. Cooke

(Address) 850 Mangold St

15-

Filed NOV 17 1920, 191.....

Robert P. Harrison, Registrar.

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....191...., to ....191....,
that I saw h.... alive on ....191....,
and that death occurred, on the date stated above, at 4.50 a m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Laryngeal TB

(Duration) yrs. 1 mos. ds.

(Signed) Shepherd D.D.Cain M. D.

11-17-20, 191.. (Address) 727 Columbia

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cemetery	Nov. 19, 1920
20-UNDERTAKER	ADDRESS
James Dignan & Son	1000 S. Paca St

Fill out all questions fully and accurately. Physicians and undertakers are required by law to report to the Health Department the cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48136

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48136

CERTIFICATE OF DEATH.

REGISTERED NO. 79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 Lemmon St ST.: 19 WARD)

2-FULL NAME Lena Mahbee

(a) RESIDENCE. No. 1319 Lemmon ST., 19 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of NO

6 DATE OF BIRTH (month, day, and year) Unknown 1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 190

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Warner McAbee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Anna Bacon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md

14 Informant Frank McAbee

(Address) 53 S. Stockton st

NOV 7 1920 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/15 1920

17 I HEREBY CERTIFY, That I attended deceased from 11/10/20, 19, to 11/15/20, 19, that I last saw h alive on 11/13/20, 19, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Mitral disease

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? 53 S Stockton

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H H Vinnedge M. D.

11/15, 19 21 (Address) 1302 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Nov 18 19 20

20 UNDERTAKER A Jones

ADDRESS 207 S Stricker St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48137 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48137

CERTIFICATE OF DEATH.

REGISTERED NO. 79

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 918 Homestead ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate E. D. Stetin

(a) RESIDENCE. NO. 918 Homestead ST.

(Usual place of abode) WARD.

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 41 mos ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced (or) WIFE of Henry Stetin

6 DATE OF BIRTH (month, day, and year) July 10-1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 006

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mc Laughlin (Address) 918 Homestead

Filed NOV 17 1920 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1918, to Nov. 16, 1920, that I last saw h[illegible] alive on Nov. 16, 1920, and that death occurred, on the date stated above, at 2.45 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency 2 mos

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. E. Hayes, M. D.

Nov. 16, 1920 (Address) 5600 York Rd. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Nov. 19—1920

20 UNDERTAKER William Cook — ADDRESS 502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D.48138

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48138

CERTIFICATE OF DEATH.

64

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6243 Bellona Ave Gorsuch 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mollie Wastler

(Residence in Baltimore: No. 6243 Bellona ave. St.; 55 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6-DATE OF BIRTH, May 25, 1863 (Month) (Day) (Year)

7-AGE, 57 yrs. 5 mos. 23 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country). Washington D C.

PARENTS.

10-NAME OF FATHER. Daniel Bigbenger.

11-BIRTHPLACE OF FATHER (State or Country). Washington - D C.

12-MAIDEN NAME OF MOTHER Katherine Lang.

13-BIRTHPLACE OF MOTHER (State or Country). Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Newton A. Wastler

(Address) 6243 Bellona Ave. Gorsuch

15-

NOV 17 1920 Filed 11-17-1920, 191

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 17, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 15 1920, to November 17 1920, that I saw h-r alive on November 16 1920, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
(High Blood Pressure)

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemmorhage

(Duration) yrs. 2 mos. ds.

(Signed) G. W. T. Bishop M. D.

Nov 17, 1920 (Address) 501 Sheridan Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Presbyterian Gorsuch	Nov. 19, 1920
20-UNDERTAKER William Cook	ADDRESS 502 E. North Ave

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48139

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48139

CERTIFICATE OF DEATH.

45

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 S Bentalou ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick J Healey

(Residence in Baltimore: No. 527 S Bentalou St St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, June 2, 1868
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
52 yrs. 5 mos. 13 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Insurance Collector
(b) General nature of industry, business, or establishment in which employed (or employer): 077

9-BIRTHPLACE, (State or Country), County Cork Ireland

PARENTS.

10-NAME OF FATHER, Jas Healey

11-BIRTHPLACE OF FATHER (State or Country), County Cork Ireland

12-MAIDEN NAME OF MOTHER Hannah Healey

13-BIRTHPLACE OF MOTHER (State or Country), County Cork Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Eva Healey

(Address) 527 S Bentalou St

15- NOV 17 1920 Robert F. Harrison,
(Date) ....., 191.....
Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 15, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 1 1920, to November 15 1920, that I saw him alive on November 1 1920, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Endocarditis Valvular

(Duration) ..... yrs. ..... mos. 8 ds.

(Signed) Robert F Harrison M. D.

Nov 17, 1920 (Address) 2051 Hollins ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Bonnie Brae Cemetery	Nov 18, 1920

20-UNDERTAKER	ADDRESS
Harry N Amacost	4204 Ridgewood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.48140 (Rinker)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48140

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE (No. ~~Elkton city md~~ St.: 4 + 175 WARD)

REGISTERED No. C

2-FULL NAME Roger Rinker

(Residence in Baltimore: No. Elkton city md St.; yrs., mos. / ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. (S.))

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Don't Know

6-DATE OF BIRTH, ... Don't Know, 1 .....
(Month) (Day) (Year)

7-AGE, About 20 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Don't Know 087
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Don't Know

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. J. Pickner & Sons

(Address) North & Penna ave

15-

Filed NOV 17 1920, 191.....

Robert P. Harrison,
Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov. 16, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull Accidentally
Struck by B. R. train at
Elkton city Md.
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accident a few minutes

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H H Jones M. D.
Coroner.

11-17 1920 (Address) 117 W Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Winchester Va. DATE OF BURIAL, Nov 17 1920

20-UNDERTAKER W. J. Pickner & Sons ADDRESS North & Penna

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

D.48141

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48141

CERTIFICATE OF DEATH.

28

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 N. Gilmore ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John N Russell

(Residence in Baltimore: No. 1117 N. Gilmore St.; 63 yrs., ... mos. ..... ds.)

Balto Md.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Sept (Month) 17 (Day), 1857 (Year)

7-AGE. 63 yrs. 1 mos. 30 ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shipcarpenter
(b) General nature of industry, business, or establishment in which employed (or employer): in ship yard

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, John N. Russell.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER dont Know

13-BIRTHPLACE OF MOTHER (State or Country), dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. M. Lackner

(Address) North & Penna Ave

15-

Filed ..... Robert P. Harrison, Registrar.

NOV 17 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 6 1920, to Nov 16 1920, that I saw him alive on Nov 15 1920, and that death occurred, on the date stated above, at 8.35 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

abt 1 (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. C. Krantz M. D.

Nov 16, 1920 (Address) 1001 N. Gilmore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Eastern Ave Cem DATE OF BURIAL, Nov 1, 1920

20-UNDERTAKER T. J. Tucker & Son ADDRESS Monument

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48142 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48142

CERTIFICATE OF DEATH. 92

1-PLACE OF DEATH

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2400 N. North ave ST.: 15 WARD)

2-FULL NAME Mary Schlechter

(a) RESIDENCE. No. 2400 N. North ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Schlechter

6 DATE OF BIRTH (month, day, and year) Jany 2 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mrs White

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER Auton Sommansatt

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Madelaine Fuchs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Geo Schlechter
(Address) 2400 N. North ave

15 Filed NOV 17 1920 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1920

17 I HEREBY CERTIFY, That I attended deceased from November 6, 1920, to November 15, 1920, that I last saw h.er alive on November 15, 1920, and that death occurred, on the date stated above, at 3.50 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Frank Q. Smith, M. D.

, 19 (Address) 927 E. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Nov 18 20
20 UNDERTAKER	ADDRESS
W. J. Tucker & Son	North ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48143 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48143

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 700 N. Fulton Ave ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Esther Jane Dennison

(a) RESIDENCE. No. 700 Fulton Ave North ST.: WARD. 16th.

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of Jno R. Dennison

6 DATE OF BIRTH (month, day, and year): Nov 15. 1840

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
—	80	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Housekeeper.

(b) General nature of industry, business, or establishment in which employed (or employer): ooo

(c) Name of employer

9 BIRTHPLACE (city or town) Ballanock (State or country) County Down Ireland

PARENTS

10 NAME OF FATHER David McGary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ellen McCracken

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Nellie R. Shannon (Address) 700 Fulton Ave

15 Filed NOV 17 1920 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 10 1920, to Nov 16 1920, that I last saw h er alive on Nov 16 1920, and that death occurred, on the date stated above, at 7.45 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexis Chronic

(duration) 3 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) ✓ yrs. ✓ mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) George C. Shannon M. D.

11/16 1920 (Address) 700 Fulton Ave North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Nov 18 1920

20 UNDERTAKER: W. J. Lickner Sons — ADDRESS: North Penn

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48144

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48144

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. New City Hospital ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Waldon

(a) RESIDENCE. No. ~~Unknown~~ 3710 E Pratt ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of minnie Waldon

~~Unknown~~

6 DATE OF BIRTH (month, day, and year) 6/23/1856

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Potter 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER John Waldon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records, (Address) New City Hospital.

15 Filed NOV 17 1920 19 Robert F Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16, 1920

17

I HEREBY CERTIFY, That I attended deceased from November 16 1920, to November 16 1920, that I last saw him alive on November 16, 1920, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) P Bteeman. M. D.

11/17/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lamb cemt — DATE OF BURIAL: Nov 20 1920

20 UNDERTAKER: Wm Cook 502 E North Ave — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.48145 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48145

CERTIFICATE OF DEATH.

64

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 509 S. Seventh St. (St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Gunsler.

(Residence in Baltimore: No.) 719 S. East Ave. (St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White.	Widow

6-DATE OF BIRTH. April 1, 1870
(Month) (Day) (Year)

7-AGE. 50 yrs. 7 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: 086
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Crown Cork & Seal Co.

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Frederick Appel.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Madeline Zoebelin.

(Address) 719 S. East Ave.

15- Filed NOV 17 1920, 191.... Registrar.

Robert P. Harrison,
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 15, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thomas Ryan Kerley M. D.
(Coroner)
Nov 17, 1920 (Address) 800 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cem.	Nov 18, 1920
20-UNDERTAKER	ADDRESS
Libby & Zink	1031 Linden Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state

D.48146 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48146

CERTIFICATE OF DEATH.

REGISTERED No. C 125

1-PLACE OF DEATH,
CITY OF BALTIMORE (No. Ford. Road Bridge P. B & W. R.R. ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William L. Allison

(Residence in Baltimore: No. 616 S. Bouldin St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White.	Single

6-DATE OF BIRTH, July (Month) 31 (Day), 1896 (Year)

7-AGE, 24 yrs. 3 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brakeman 073
(b) General nature of industry, business, or establishment in which employed (or employer): P. W. & B. R.R.

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, George J. Ellison

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Emma J. Bloom

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Emma J. Ellison
(Address) 616 S. Bouldin St.

15- Filed NOV 17 1920, 191.... Robert P. Harrison, Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mutilated Injuries - Accident P. B. & W. R.R.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo. Edmon Pfeltz M. D.
(Coroner)
11/16/20, 191... (Address) 1726 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Lehnert's Cem.	Nov. 18, 1920
20-UNDERTAKER	ADDRESS
Selby & Son	413 Bond

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48147

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48147

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 404 S. Highland Ave ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hohenstein

(a) RESIDENCE. NO. 404 S. Highland Ave ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Hohenstein

6 DATE OF BIRTH (month, day, and year) Dec. 22 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Michael Schrader

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Hummer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick Hohenstein
(Address) 404 S. Highland

15 Filed NOV 17 1920 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1920

17 I HEREBY CERTIFY, that I attended deceased from May 8th 1920 to Nov. 15th 1920

that I last saw h... alive on Nov. 7th 1920

and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulm. Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cor. Stenosis

(duration) yrs. One mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. F. Cover, M. D.

(Address) 1570 Edgecombe Cir

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem.

DATE OF BURIAL: Nov. 18 1920

20 UNDERTAKER: Lilly & Zeh

ADDRESS: 403 S. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

1048148

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048148

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 N Rose ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Zdenek

(Residence in Baltimore: No. 719 N Rose St.; 3 yrs., 10 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, Jan (Month) 22 (Day), 1917 (Year)

7-AGE, 3 yrs. 10 mos. 27 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Zdenek

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Mary Novak

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Zdenek

(Address) 719 N Rose St

15-

Filed....., 192.. ROBERT J. KRAUSE Registrar.

NOV 18 1920

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 18 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 16 1920, to Nov 18 1920, that I saw h[illegible] alive on Nov 17 1920 and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) M Kuzniecz M. D.

11-18, 1920 (Address) 800 N Patterson Pk Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer | DATE OF BURIAL, Nov 19, 1920

20-UNDERTAKER Frank Crockett | ADDRESS 1906 Gorsuch Ave

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

L48149

HEALTH DEPARTMENT—CITY OF BALTIMORE

L48149

CERTIFICATE OF DEATH.

40

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 N. Eutaw ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Smrha

(Residence in Baltimore: No. 427 N. Eutaw St.; 28 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, ... 47 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Home

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Frank Popalecky

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Wolf

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Smrha

(Address) 427 N. Eutaw St

15- NOV 18 1920 ROBERT B KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 6 1920, to Nov 15 1920, that I saw h.. alive on Nov 15 1920, and that death occurred, on the date stated above, at 12.05 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

..... (Duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) Contusion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J. Chrisman M. D.

Nov 17, 1920 (Address) Patterson Pk

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Nov 19, 1920
20-UNDERTAKER	**ADDRESS**
Frank Brack & Son	1300 Garland Av

Important. See instructions on back of certificate. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

1048150

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048150

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 N Front ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Lee

(Residence in Baltimore: No. 100 N Front St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov (Month) 1 (Day) 1870 (Year)

7-AGE, 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment: in which employed (or employer). Odd Jobs

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, William Lee

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Mary Cahill

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Lee

(Address) 1002 Eastland Ave

15 NOV 18 1920 ROBERT P KRAUTER

Filed....., 191... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 16, 1920, to Nov 16, 1920, that I saw h[illegible] alive on 16 day Nov 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary T.B.

(Duration) yrs. 6 mos. ds.

(Signed) Joseph J. Mullen M. D.

Nov 16, 1920 Address 1634 Bank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loby Grove — DATE OF BURIAL, Nov 18, 1920

20-UNDERTAKER Paul Craft Son — ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D48151

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48151

CERTIFICATE OF DEATH.

40

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 Lincoln St ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Drochaska

(Residence in Baltimore: No. 2013 Lincoln St St.; 34 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year)

7-AGE, 55 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Frank Drochaska

11-BIRTHPLACE OF FATHER (State or Country). Bohemia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosalora Drochaska

(Address) 2013 Lincoln St

Filed NOV 18 1920, 191.. ROBERT B KRAUTER BURIAL PERMIT CLERK

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Nov. 16 1920, that I saw h[illegible] alive on Nov 16 1920, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Uraemic Convulsions

..... (Duration) ..... yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Nov. 17, 1920 (Address) 1801 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Oak Hill — DATE OF BURIAL, Nov 18, 1920

20-UNDERTAKER Frank Leach Son — ADDRESS 1910 Eutaw Pl

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048152

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048152

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 W. York ST.: 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Davis

(a) RESIDENCE. NO. 18 W. York ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rena Davis

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54 (about)	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Cooling Physic Co

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Elams N. C.

PARENTS

10 NAME OF FATHER Louis H. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Elams N. C.

12 MAIDEN NAME OF MOTHER Lavinia Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Elams N. C.

14 Informant (Address) Benj. Davis 1237 4th Norfolk Va.

15 NOV 18 1920 ROBERT J. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 9th, 1920, to Nov 16th, 1920, that I last saw him alive on Nov 14th, 1920, and that death occurred, on the date stated above, at 8.25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D. H. Carroll, M. D.

(Address) 145 W. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	11-19 1920
20 UNDERTAKER W. Doyle	ADDRESS 15 E. Lee St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

2048153 HEALTH DEPARTMENT—CITY OF BALTIMORE 2048153

CERTIFICATE OF DEATH.

105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 S. Bethel ST.; 2 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Jagodzinski

(Residence in Baltimore: No. 516 S Bethel St.; 2 yrs., 10 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Child

6-DATE OF BIRTH. Jan 28, 1918 (Month) (Day) (Year)

7-AGE. 2 yrs. 9 mos. 20 da. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 00

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Ricadem Jagodzinski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Michalina Wasiecha

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michalina Wasiecha

(Address) 516 S Bethel

15- NOV 18 1920 ROBERT E KRAUTER

Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 17, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 13 1920, to Nov. 15 1920, that I saw him alive on 1920, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Stomatitis

over

(Duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. 1 mos. da.

(Signed) A. J. Freudau M. D.

Nov. 17, 1920 (Address) 918 E. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Nov. 18, 1920
20-UNDERTAKER	**ADDRESS**
John M Weber	1803 Bank St

important. See instructions on back of certificate.

Spec.—6-9-19—R. P. Co.—1000 Blks.

D48154 HEALTH DEPARTMENT—CITY OF BALTIMORE D48154

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 322 S ann st ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Grat

(a) RESIDENCE. No. 322 S Ann ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Grat

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Josephine Mechlinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Josephine Mechlinska
(Address) 322 S Ann

15 Filed NOV 18 1920 ROBERT I. KRAETER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1920, to Nov 17, 1920, that I last saw h.r alive on Nov. 17, 1920, and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Septic Sore Throat

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Septic Endocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Cygnet Jr. M. D.

19 (Address) 804 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Nov 19 1920
20 UNDERTAKER	ADDRESS
John F. Weber	1803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 48155

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X D 48155

16 V 1887 Sept 20

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett A Brown

(a) RESIDENCE. No. 1007 McCulloh ST., WARD. Camden NJ

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William A Brown

6 DATE OF BIRTH (month, day, and year) Sept 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hartsburn Md

PARENTS

10 NAME OF FATHER William Carpenter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anny Jefferson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant William A Brown (Address) Hartsburn Md

15 Filed NOV 18 1920 ROBERT B. LAWTON Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1920, to Nov 17, 1920, that I last saw h.. alive on Nov 17, 1920, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows: OVER

Acute Parenchymatous Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 1007 McCulloh St

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Fitzgerald, M. D.

11/17 1920 (Address) 1118 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
James McC Lynch Hartsburn Md	Nov 18 1920
20 UNDERTAKER Clarence Enright	ADDRESS 1364 McCulloh

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 48156

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D 48156

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3114 Strickland St.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Ruth Kirby.

(a) RESIDENCE. No. 3114 Strickland St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of child

6 DATE OF BIRTH (month, day, and year) Apr 28/920.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Elias J. Kirby.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lillian M Starck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Elias J. Kirby. 3114 Strickland St

15 Filed NOV 18 1920 ROBERT P. BEUTLER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1920, to Nov 17, 1920, that I last saw her alive on Nov 16, 1920, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteric Intoxication.

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? c

Did an operation precede death? No Date of No

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Howard W Jones M. D.

(Address) 222 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Nov 18/20
20 UNDERTAKER Wm Cook	ADDRESS 22 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 48157

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48157

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1137 Riverside Ave. ST.: 24th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carroll Anderson.

(Residence in Baltimore: No. 1137 Riverside Ave. St.: yrs., 4 mos. 23 ds.)

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state AGE carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male.	White.	Single.

6-DATE OF BIRTH. June 19th. 1920., 1 (Month) (Day) (Year)

7-AGE. ---yrs. 4 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Gustave Anderson.

11-BIRTHPLACE OF FATHER (State or Country), Sweden.

12-MAIDEN NAME OF MOTHER Myrtle Montgomery.

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gustave Anderson. (father)

(Address) 1137 Riverside Ave.

15- ROBERT B KRAUTER

Filed....., 191..... Registrar.

NOV 18 1920 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 17th. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritus.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Bernhardt M. D. (Coroner.)

Nov. 17., 1920. (Address) 1517 E. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Nov 18th 1920
20-UNDERTAKER	ADDRESS
John J Cowan & Son	701 Hollins St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48158

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D48158

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 842 St. Peter ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Wilbur Johnson

(a) RESIDENCE. No. 842 St Peter ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Finland

12 MAIDEN NAME OF MOTHER Ada Sharpe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant John Johnson (Address) 842 St Peter St.

15 Filed NOV 18 1920 ROBERT E. LEADER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1920, to Nov 16, 1920, that I last saw h.... alive on Nov 16, 1920, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Enteritis Acute

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edw Smith, M. D.

11/18. 1920 (Address) 517 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov. 19 1920
20 UNDERTAKER	ADDRESS
H. Sander & Son	1710 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48159

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

392 D48159

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 838 E. Preston ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Edwards

(a) RESIDENCE. No. 838 E. Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 12, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Letter Carrier

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles F. Edwards

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline V. Cullimore

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Mrs Harriet E. Riley
(Address) 838 E. Preston St

15 Filed NOV 18 1920 ROBERT E. KRAFFERT Registrar

Burial Permit Oferd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16th 1920

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1920, to Nov. 16, 1920, that I last saw him alive on Nov. 15, 1920, and that death occurred, on the date stated above, at 5 40 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma tongue, with metastasis to glands of neck.

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Jaundice ?

(duration) ½ yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 17, 1920

Was there an autopsy? No.

What test confirmed diagnosis? Microscopical

(Signed) Robt Hamilton M. D.

19 (Address) 18. W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Nov. 26 1920
20 UNDERTAKER	ADDRESS
H. Sanders & Son	1710 Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

048160 HEALTH DEPARTMENT—CITY OF BALTIMORE 048160

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2008 Fountain St ST.: 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna V. McNeil

(a) RESIDENCE. No. 2008 Fountain ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Beverly A. McNeil

6 DATE OF BIRTH (month, day, and year) March 6-1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Helen Krebs
(Address) 416 N Stricker St.

15 Filed NOV 18 1920 ROBERT I. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1920

17 I HEREBY CERTIFY, That I attended deceased from June 17, 19 19, to Nov 15, 19 20, that I last saw h Ex alive on Nov 15, 19 20, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstat Nephritis

Edema (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C K Meyer Jr M. D.

11/15, 19 20 (Address) 2637 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Nov. 18 1920
20 UNDERTAKER	ADDRESS
A. Sandow & Son	710 Fleet St.

Spec.—6-9-19—E. P. Co.—1000 Bks.

D48161 HEALTH DEPARTMENT—CITY OF BALTIMORE D48161

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Reavy

(a) RESIDENCE. No. 923 E. Lombard St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipbuilder

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER M. Reavy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Savage

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Hospital Records, New City Hospital.

15 Filed NOV 18 1920 ROBERT A. LEAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15, 1920

17 I HEREBY CERTIFY, That I attended deceased from August 6, 1919 to November 15, 1920 that I last saw him alive on November 14, 1920 and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Urethral Stricture 0021

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Holden M. D.

19 (Address) Bay View Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
K	NOV 17 1920
20 UNDERTAKER	ADDRESS
WOODALL	

52

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48162

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48162

CERTIFICATE OF DEATH.

28

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3002 Elliott ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Dziecichowicz

(a) RESIDENCE. No. 3002 Elliott ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife

6 DATE OF BIRTH (month, day, and year): 1896-1-24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Aug Dziodek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Casmer Dziechowski

(Address) 3002 Elliott St

15 Filed NOV 18 1920 ROBERT I. LEAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14 20, to Nov 17, 20,

that I last saw her alive on Nov 16, 20,

and that death occurred, on the date stated above, at 4-a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

3 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Wm. Insley M. D.

. 19 (Address) 933 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Nov 19 1920

20 UNDERTAKER: Stephen J. Fialkowski

ADDRESS: Woodberry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48163 ✓ 81 D48163

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 829 N. Gay Street ST.; 10 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Stein

(Residence in Baltimore: No. 829 N. Gay Street St.; 21 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	Widow

6-DATE OF BIRTH, Unknown (Month) ....., (Day) 1835 (Year)

7-AGE, 85 yrs. mos. ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1411 E. Baltimore St

15-

Filed NOV 18 1920 191.....

ROBERT E. KRAFFT
Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 15th (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 20 191, to Nov. 15th 191, that I saw h... alive on Nov. 15th 191, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Cystitis Catarrhalis
Senile Debility Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Mem. Gardens	11/17, 1920
20-UNDERTAKER Jack Lewis	ADDRESS 1411 E. Balt St

important. See instructions on back of certificate.

D48164 HEALTH DEPARTMENT—CITY OF BALTIMORE D48164

CERTIFICATE OF DEATH. X 170

1-PLACE OF DEATH

CITY OF BALTIMORE (No. University Hospital ST.: 4 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Daily

(Residence in Baltimore: No. Dorsey station md St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH. July 27, 1901 (Month) (Day) (Year)

7-AGE. 19 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. George Daily

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Eva Culver

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Daily

(Address) Dorsey Md

15-NOV 18 1920 ROBERT B KRAUTER

Filed....., 191.... Registrar.

Burial Permit No.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 17, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said..... (~~Inquest, autopsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Gas bacillus Pneumonia due to Gun shot wound in Left leg.

..... (Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Accidentally Shot by Elmer Baker

..... (Duration) yrs. mos. 3 ds.

(Signed) H K Samuel M. D. (Coroner.)

11-17-, 1920 (Address) 117 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Dorsey Md. DATE OF BURIAL, Nov 19, 1920

20-UNDERTAKER E & B Hahn ADDRESS 115 E Wash St

CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate.

048165 HEALTH DEPARTMENT—CITY OF BALTIMORE 048165

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2309 N C Eldenor St. WARD)
2-FULL NAME Edna M Bowley
(Residence in Baltimore: No. 2309 N C Eldenor St.: yrs., mos. ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Female	Col	Married

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) — (Year)

7-AGE 50 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Work
(b) General nature of industry, business, or establishment in which employed (or employer): House Work

9-BIRTHPLACE, (State or Country), born in Baltimore City

PARENTS.
10-NAME OF FATHER, John Wilson
11-BIRTHPLACE OF FATHER (State or Country), Balt
12-MAIDEN NAME OF MOTHER Ellen Harris
13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Martha John Wilson
(Address) 2309 N Eldenor St

15- Filed NOV 18 1920, 191. ROBERT B KRAUTH Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov (Month) 16 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.
The CAUSE OF DEATH* was as follows:
Chron Contusion Nephritis
(Duration).....yrs.....mos.....ds.
CONTRIBUTORY (Secondary)
(Duration).....yrs.....mos.....ds.
(Signed) H Quigley M. D.
11-17, 1920 Address 1725 Eden St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laural Cemetery — DATE OF BURIAL, Novem 19. 1920
20-UNDERTAKER Mrs Robert Elliott — ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

J. J. Walter Edmonds

D48166 HEALTH DEPARTMENT—CITY OF BALTIMORE D48166

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Bells & Gay St. 2479 WARD) REGISTERED No. C

2-FULL NAME J. & W. Edmonds

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1214 Ballery Ave St.; yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept. 26 (Month) (Day), 1884 (Year)

7-AGE, 36 yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Bldr

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, J. Edmonds

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER E. Pilcher

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Edmonds

(Address) 1214 Ballery

15- [illegible] E KRAUTER Registrar.

NOV 18 1920 191.... Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 15 (Month) (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. dis. heart

Dur. Rheu. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation

(Duration) yrs. mos. ds.

(Signed) H. S. Bailey M. D.

Nov 17, 1920 (Coroner) 1537 Bond (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death....yrs.....mos.....ds. In the State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pa. Co. Md — DATE OF BURIAL, Nov. 18, 1920

20-UNDERTAKER John J. Fahey & Sons — ADDRESS 1318 Light St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48167

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48167

CERTIFICATE OF DEATH.

10-691

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 Pennsylvania Ave ST.. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jno. Franklin Holland

(a) RESIDENCE. No. 1206 Penna. Ave ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wht.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Sweeney

6 DATE OF BIRTH (month, day, and year) Sept. 29 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
born 1860	60	Sept Dec	29 / 18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. S. Navy Yard.

9 BIRTHPLACE (city or town) (State or country) Balto Co. now in city

PARENTS

10 NAME OF FATHER Chas G. Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Md.

12 MAIDEN NAME OF MOTHER Sarah R. Lydden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jno O. Holland

(Address) 1202 Penna. Ave

15 Filed NOV 18 1920 19 ROBERT E [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7 1920, to Nov. 17th 1920, that I last saw him alive on Nov. 17th 1920, and that death occurred, on the date stated above, at 1300 P. m.

The CAUSE OF DEATH* was as follows:

La Grippe & Bronchitis
To Broncho Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Heart failure 2 hrs.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In Washington

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? auscultation

(Signed) Chas Smith, M. D.

19 (Address) 162 S W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Nov. 20 19 20
20 UNDERTAKER	ADDRESS
M Hackey & Sons	1837 10 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1046168 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 1046168

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2611 E. Preston St.: 8 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Joseph McMahon

(a) RESIDENCE. No. 2611 E. Preston St., WARD.
(Usual place of abode) About
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 40 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine McMahon

6 DATE OF BIRTH (month, day, and year) March 17, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	7	19	

8 OCCUPATION OF DECEASED 086

(a) Trade, profession or particular kind of work Solicitor - American

(b) General nature of industry, business, or establishment in which employed (or employer) Ice Company

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John McMahon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Gallery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Catherine McMahon
(Address) 2611 E. Preston Street

15 Filed NOV 18 1920 16 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1919, to Nov 16, 1920, that I last saw him alive on Nov 16, 1920, and that death occurred, on the data stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis
14

(duration) yrs. 14 mos. -- ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) -- yrs. -- mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. J. Powers, M. D.

, 19 (Address) 921 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	11/19, 1920
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48169 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48169

151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 N. Parrish ST.; 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Johnson

(Residence in Baltimore: No. ..... St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
M	B	Single

6-DATE OF BIRTH, Nov (Month) 13 (Day), 1917 (Year)

7-AGE, ... yrs. 3 mos. 23 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thos J Harrison

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Helen Jackson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- Robert P. Harrison, Burial Permit Clerk
NOV 18 1920, 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 14 (Day), 191 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I saw h alive on Nov 14 1920,
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
6 to 7 days

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward A Morgan M. D.
Nov 17, 191.. (Address) 1322 Hanlon

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL JOHNS HOPKINS HOSPITAL. DATE OF BURIAL, NOV 18 1920, 191...

20-UNDERTAKER Commissioner Health. ADDRESS

Per Wm. E. WOODALL.

Important. See instructions on back of certificate. Any one properly classified. Exact statement of OCCUPATION is very

Spec.--6-9-19—H. P. Co.—1000 Pks.

D.48170

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48170

170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2733 Eastern ave ST.; 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Konig

(a) RESIDENCE. NO. 2733 Eastern ave ST., 1 WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of George Konig

6 DATE OF BIRTH (month, day, and year) June 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	5	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Schroeder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Hillen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Margaut Konig
(Address) 2733 Eastern ave

NOV 18 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1920, to Nov. 16, 1920, that I last saw her alive on Nov 16, 1920, and that death occurred, on the date stated above, at 1/30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Tubal Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) No other cause

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. K. Long, M. D.

11/19 1920 (Address) 2701 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	11/19 1920
20 UNDERTAKER J J Moran	ADDRESS 3000 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48171 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48171

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 Mc Henry st ST.) 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minna Redemann

(a) RESIDENCE. No. 722 Mc Henry st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 7 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, ~~Married, Widowed~~ or Divorced ~~(write the word)~~: Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 3 1856

7 AGE — Years: 64 Months: 7 Days: 13 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: William Redemann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germy

12 MAIDEN NAME OF MOTHER: Elizabeth Fogerle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germy

14 Informant: William Redemann (Address) 722 Mc Henry st

15 Filed ..., 19... Registrar

NOV 18 1920 Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1920, to Nov 16, 1920, that I last saw h[illegible] alive on Nov 16, 1920, and that death occurred, on the date stated above, at 10 40 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd, M. D.

Nov 18, 1920 (Address) 62 Holme Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 19 1920
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	2178 Pine

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D. 48172

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48172

CERTIFICATE OF DEATH.

173

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 319 S Calhoun ST.; 19 WARD)

2-FULL NAME Jno Conrad. T Ran

(a) RESIDENCE. NO. 319 S. Calhoun ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 2 Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Emily T Ran

6 DATE OF BIRTH (month, day, and year): Aug. 15 1861

7 AGE — Years: 59 Months: 4 Days: 3 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Henry C Ran

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Kath Nickel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Emily T Ran
(Address): 319 S. Calhoun st

15 Filed NOV 18 1920 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 18. 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1920, to Nov 18, 1920, that I last saw h[illegible] alive on Nov 17th, 1920, and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

Exanstion

(duration) ..... yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary): Stomach Disorders

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 10

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) John F Schwinsberg M. D.

19 (Address) 1120 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Nov 20 192
20 UNDERTAKER: Jos Sverdens Son	ADDRESS: 217 S. P...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact [illegible] should state TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48173

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48173

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 540 Lambert ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Williams

(a) RESIDENCE. No. 540 Lambert ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Williams

6 DATE OF BIRTH (month, day, and year) May 10 1853.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic D°

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Charlestown W. Va.

PARENTS

10 NAME OF FATHER Toney Bluck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Loudon Co. Va.

12 MAIDEN NAME OF MOTHER Caroline Redman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Louden Co. Va.

14 Informant Mary Williams

(Address) 540 Lambert

15 Filed Nov 18 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1920, to Nov 16, 1920, that I last saw h[illegible] alive on Nov 15, 1920, and that death occurred, on the date stated above, at 8.15 m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteno Sclerosis -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 540 Lambert St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Clinical

(Signed) Wm F Wright, M. D.

(Address) 1309 Presstman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 21 1920
20 UNDERTAKER	ADDRESS
Daniel Earley	916 Bond ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.48174 HEALTH DEPARTMENT--CITY OF BALTIMORE D.48174

Staskunas

CERTIFICATE OF DEATH

91

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 906 E. Pratt st Ward 3)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva Staskunas

(Residence in Baltimore: No. 906 E. Pratt St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Infant

6-DATE OF BIRTH: ~~Dec~~ 12 — (Month) (Day), 1912 (Year)

7-AGE: 7 yrs. 11 mos. 6 ds. If LESS than 1 day, ... hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer): Infant

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Adam Staskunas

11-BIRTHPLACE OF FATHER (State or country): Russia Lithuania

12-MAIDEN NAME OF MOTHER: Eva Saklitzka

13-BIRTHPLACE OF MOTHER (State or country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adam Staskunas

(Address) 906 E. Pratt St.

15- NOV 18 1920

Robert P. Harrison, 191

Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Nov 18, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1916 to Nov 17 1920 that I saw her alive on Nov 17 1920 and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Imbecility
Rachitis

(Duration) 5 yrs. mos. ds.

Contributory (SECONDARY) Inanition terminal bronchopneumonia

(Duration) yrs. 3 mos. ds.

(Signed) Herman Seidel M. D.

Nov 18 1920 (Address) 2404 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Stanislaus — DATE OF BURIAL: Nov 20 1920

20-UNDERTAKER: John L. Grebliunas — ADDRESS: 425 S. Paca St.

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Neison

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48175

143942 D48175

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Nelson.

(a) RESIDENCE. NO. 829 W. Fayette St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Feb. 28. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam Fitter

(b) General nature of industry, business, or establishment in which employed (or employer) 060

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mississippi

PARENTS

10 NAME OF FATHER Sebastian Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) on the seas near France

12 MAIDEN NAME OF MOTHER Marguerite Stark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germ.

14 Informant ....

(Address)

15 FILED NOV 19 1920 ROBERT E. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17. 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 21- 1920, to Nov 17 1920, that I last saw h im alive on. Nov 17 1920, and that death occurred, on the date stated above, at 8 55 a m.

The CAUSE OF DEATH* was as follows:

Cancer of Lung

(duration) yrs. 6 ± mos. ds.

CONTRIBUTORY (Secondary) ....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. R. Mason, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Nov 20 1920
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Fayette Street

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048176 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048176

CERTIFICATE OF DEATH. 130-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard Park. Belleville & Milford Aves. ST.; 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia C. Lawton

(a) RESIDENCE. NO. 3009 E. Preston St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jervis Lawton

6 DATE OF BIRTH (month, day, and year) Nov. 14, 1844

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) "

12 MAIDEN NAME OF MOTHER Unknown "

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant T. Wilbur Lawton (Address) 3009 E. Preston St.

15 Filed NOV 19 1920 ROBERT P. KRAUTER Registrar Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16" 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov. 5 - 1920. to Nov. 16 - 1920

that I last saw her alive on Nov. 16 - 1920

and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis. (duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis?

(Signed) J. Boardman, M. D.

. 19 (Address) 2125 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov. 19 1920
20 UNDERTAKER Joseph B. Cook.	ADDRESS 1003 N. Bells Street

2048177 HEALTH DEPARTMENT—CITY OF BALTIMORE 2048177

CERTIFICATE OF DEATH.

175-004

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Marion Leach.

(Residence in Baltimore: No. 4320 Pimlico Road. St.: 89 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White.	Married.

6-DATE OF BIRTH, February 27th. 1842, 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
78 yrs. 8 mos. 13 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk, E. & O. R. R. Co
(b) General nature of industry, business, or establishment in which employed (or employer): 004

9-BIRTHPLACE, (State or Country), St. Marys Co. Md.

PARENTS.

10-NAME OF FATHER, George R. Leach.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Eleanor King.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma R. Leach. (wife)

(Address) 4320 Pimlico Road.

15- Filed NOV 19 1920, 191.... ROBERT E KRAUTER Registrar. Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 18th. 1920., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Lobular pneumonia, fractured ribs & femur, Accidentally struck by car #666 of W. B. & A. R. R. Co. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Wm. H. Leonhardt M. D. (Coroner.)

Nov. 19th, 191.20 (Address) 1017 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? Fort Meigs & Virginia Cases.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cem	Nov. 19..., 1920
20-UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

K48178

HEALTH DEPARTMENT—CITY OF BALTIMORE

K48178

CERTIFICATE OF DEATH.

91-029

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 503 N. Biddle St.; 17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pearl Godsey

(Residence in Baltimore: No. 503 N. Biddle St.; yrs. 23 mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Negro

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, Dec (Month) 25 (Day), 1918 (Year)

7-AGE, 1 yrs. 10 mos. 28 da.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Pearl Godsey

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Jane Lowell

13-BIRTHPLACE OF MOTHER (State or Country), Calvert Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane Godsey

(Address) 503 N. Biddle

15. Filed NOV 19 1920, 191.... ROBERT B KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 17 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 1920, to Nov 17 1920, that I saw h[illegible] alive on Nov 16 1920, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 17 da.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) ..... yrs. ..... mos. 14 da.

(Signed) J. Enos Roe M. D.

11-17, 1920 (Address) 739 Georgia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: Nov. 19, 1920

20-UNDERTAKER: Samuel Newby

ADDRESS: 378 N Bradford

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Mary G. Wyatt

D48179

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48179

CERTIFICATE OF DEATH.

109

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary G. Wyatt. (C)

(Residence in Baltimore: No. 520 Lambert st. St.: 39 yrs., mos. da.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female.	Colored.	Married.

6-DATE OF BIRTH, October 14th. 1880, 1
(Month) (Day) (Year)

7-AGE, 39 yrs. 1 mos. 2 da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None. 057
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Westminster, Md.

PARENTS.

10-NAME OF FATHER, John Jackson. (C)

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER Etta Twinge. (C)

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Roger Wyatt. (C) Husband.

(Address) 520 Lambert st.

15- NOV 19 1920 Filed, 191. ROBERT B KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 16th. 1920, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction.
Pelvic infection.

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) Chas. L. Emmanuel M. D.
(Coroner.)

Nov. 17th 1920 (Address) 10 E. Chase st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

520 Lambert st.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn

DATE OF BURIAL, 11/19/20

20-UNDERTAKER Samuel T. Hemsley

ADDRESS 578 N. Pine

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048180 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048180

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: ? WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert W. Clark.

(a) RESIDENCE. No. 1638 Henry St Augusta Ga. WARD. Augusta Ga.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Anna H Clarke

6 DATE OF BIRTH (month, day, and year) Aug 8 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga

PARENTS

10 NAME OF FATHER Job G H Clark

11 BIRTHPLACE OF FATHER (city or town) S. Ca. (State or country)

12 MAIDEN NAME OF MOTHER Harriett Frazer

13 BIRTHPLACE OF MOTHER (city or town) Ga (State or country)

14 Informant Hospital Record (Address) J. H. H.

15 Filed NOV 19 1920 ROBERT I. LEAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 13 . 1920, to Nov 18 . 1920, that I last saw h... alive on Nov 18th . 1920, and that death occurred, on the date stated above, at 5 00 a m.

The CAUSE OF DEATH* was as follows:

Intrathoracic Tumor -
(myxo-chondroma of the rib)

(duration) 5 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Operation - Removal of Tumor (duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov. 18, 1920

Was there an autopsy? no

What test confirmed diagnosis? Removal of Tumor

(Signed) Mont R Reid, M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Augusta Ga	Nov 18 19
20 UNDERTAKER	ADDRESS
Henry H Jenkins & Son	Oakland Ga

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048181

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048181

CERTIFICATE OF DEATH.

79

1-PLACE OF DEATH

CITY OF BALTIMORE: ~~No.~~ 432 N. Carrollton Ave ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Agnes Crow

(a) RESIDENCE. NO. 432 Carrollton Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widowed

5a ~~Married~~, widowed, or ~~divorced~~ ~~WIFE~~ of (or) WIFE of Wm. H. R. Crow.

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE: Years 59 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Robert McSmith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Margaret A Judah

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: David J.T. Crow (Address) 432 N. Carrollton Ave

15 NOV 19 1920 ROBERT F. KRAUTER Registrar

Burial Permit Oleis

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 18th 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 15th 1920 to Nov 18th 1920, that I last saw ~~he~~ alive on Nov 18th 1920, and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH was as follows:

Fatty Degeneration of the Heart

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What tests confirmed diagnosis?

(Signed) Howard Lockard M. D.

Nov 18. 1920 (Address) 707 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Nov 22. 1920

20 UNDERTAKER: William Cook — ADDRESS 1522 E. Mt Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

K048182

HEALTH DEPARTMENT—CITY OF BALTIMORE

2048182

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2137 N.W. Smallwood St., 15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Wm. Jones

(a) RESIDENCE. No. 2137 N.W. Smallwood St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ada. Jones.

6 DATE OF BIRTH (month, day, and year): Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shell Worker

(b) General nature of industry, business, or establishment in which employed (or employer): Coo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): A. A. Co Md

PARENTS

10 NAME OF FATHER: Richard Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): A. A. Co Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Owen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): A. A. Co Md.

14 Informant: Arthur Jones

(Address): 2137 N.W. Smallwood

15 Filed NOV 19 1920 ROBERT T. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1920, to Nov 17, 1920, that I last saw him alive on Nov 17, 1920, and that death occurred, on the date stated above, at 2051 m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Chronic Interstitial Nephritis - unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Walter A. Cox, M. D.

19 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Marlboro Md

DATE OF BURIAL: Nov 20 1920

20 UNDERTAKER: William Cook

ADDRESS: 502 E Nadi

Spec.—6-9-19—H. P. Co.—1000 Bks.

1048183

HEALTH DEPARTMENT—CITY OF BALTIMORE

1048183

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 380 S Mt Pleasant Av ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gotthardt Reinhardt

(a) RESIDENCE. NO. 380 S Mt Pleasant Av ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte Reinhardt

6 DATE OF BIRTH (month, day, and year) April 9 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker 003

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charlotte Reinhardt
(Address) 380 S Mt Pleasant Av

15 Filed NOV 19 1920 ROBERT I. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1920 to Sept 4, 1920, that I last saw h[illegible] alive on Sept 4, 1920, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis - Uremic Poisoning - Chronic Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mutual Benefit Society

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. W. Faulcon, M. D.

Nov. 19 20 (Address) 350 S Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Nov 19 19
20 UNDERTAKER J Herwig & Co	ADDRESS 2005 Orleans

O.K.—B. Claus for Wades Pt. Coroner at Large

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Rosena Schaffner

D48184

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48184

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 233 E. Clinic (St.) 8 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosena Schaffner

(a) RESIDENCE. No. 233 E. Clinic St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry L. Schaffner

6 DATE OF BIRTH (month, day, and year): Feb 23 1866

7 AGE ~~54~~ Years ~~2~~ Months ~~25~~ Days: 54 8 24

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Havre de Grace, Md

PARENTS

10 NAME OF FATHER: Andrew G. Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Havre de Grace Md

12 MAIDEN NAME OF MOTHER: Carrie Payne

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Havre de Grace Md

14 Informant: Henry L. Schaffner

(Address) 233 E. Clinic St.

15 NOV 19 1920

ROBERT E KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 17th 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 5th, 1920, to Nov 17th, 1920, that I last saw her alive on Nov 17th, 1920, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary): Tubercular Bacillus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 824 N. Washington St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) Edward H. Worrell M. D.

, 19 (Address) 2432 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Nov 22 1920

20 UNDERTAKER: J Herwig & Co

ADDRESS: 2005 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48185 HEALTH DEPARTMENT—CITY OF BALTIMORE D48185

CERTIFICATE OF DEATH.

4 79

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 Pearle ST.; 4 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm L. Marcks

(Residence in Baltimore: No. 21 Pearl St St.; 60 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Sept 3, 1852
(Month) (Day) (Year)

7-AGE, 68 yrs. 2 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk & Dog
(b) General nature of industry, business, or estsblishment in which employed (or employer)..... Book Keeper

9-BIRTHPLACE, (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Augusta Marcks

(Address) 21 Pearl St

15- NOV 19 1920 ROBERT E KRAUTER

Filed....., 191.....

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 18th, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 25th 1920, to Nov 18th 1920, that I saw h.. alive on Nov. 17th 1920, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease
Mitral incompetency

(Duration) 1 yrs. 12 mos. ds.

CONTRIBUTORY (Secondary) None known

(Duration) yrs. mos. ds.

(Signed) Chas J Keller M. D.

Nov 18, 1920 (Address) Mt Vernon Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Western Cemetery	Nov 20., 1920
20-UNDERTAKER	ADDRESS
W M Rountree	230 N Green

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48186 HEALTH DEPARTMENT—CITY OF BALTIMORE D48186

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 747 W. Mulberry St.: 4 Ward) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Lewis

(a) RESIDENCE. No. 747 Mulberry St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE: Years 53 Months unknown Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 870

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Rachael Watson (Address) 747 Mulberry St

NOV 19 1920

ROBERT P. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1920, to Nov 16, 1920, that I last saw h[er] alive on Nov 15, 1920, and that death occurred, on the date stated above, at 3:29 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis (duration) yrs. 1 3/1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. McCard, M. D.

11/17, 1920 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Nov 19 1920
UNDERTAKER	ADDRESS
Chas. L. Bailey	142 Jefferson st

Spec.—6-9-19—H. P. Co.—1000 Bks.

048187 HEALTH DEPARTMENT—CITY OF BALTIMORE 048187

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1347 N Carey ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur Ford

(a) RESIDENCE. No. 1347 N Carey ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colrd	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Nov. 9 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Arthur Ford

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Cora Johnson

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Cora Johnson (Address) 1347 N Carey St

15 NOV 19 1920

ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 17, 1920, to Nov 18, 1920, that I last saw him alive on Nov 17, 1920, and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (Primary)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? .....

(Signed) William Frey, M. D.

11/18, 1920 (Address) 1924 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 19 1920
20 UNDERTAKER	ADDRESS
Clarence E. Wright	1367 Pacany

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D48188

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48188

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Ten Hills Wood Side ST.; [illegible] WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ann Howard

(Residence in Baltimore: No. Wood Side Road St.; hp yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, June (Month) 16 (Day), 1830 (Year)

7-AGE. 90 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic Duties
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, James Howard

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Ann Howard

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maria White

(Address) Wood Side Road Ten Hills

15-

Filed NOV 19 1920, 191

ROBERT B KRAUTER
Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from [illegible] 1920, to Nov 17 1920, that I saw h[illegible] alive on about 3 months prev 191, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Brights Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 3 yrs

(Duration) yrs. mos. ds.

(Signed) Wm Dulany Thomas M. D.

Nov 17, 1920 (Address) 330 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Star (Balto Co) DATE OF BURIAL, Nov. 21, 1920

20-UNDERTAKER Easton Sons ADDRESS Ellicott City

may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D48189 HEALTH DEPARTMENT—CITY OF BALTIMORE D48189

CERTIFICATE OF DEATH.

9 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3031 Monument ST.; 9 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Marie Carey

(Residence in Baltimore: No. 3031 E. Monument St.; 27 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, May 23, 1893
(Month) (Day) (Year)

7-AGE, 27 yrs. 6 mos. 26 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Edw J Carey

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Margaret Demel

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw Carey

(Address) 3038 E Monument

15- NOV 19 1920 ROBERT E KRAUTER Registrar.
Filed ....., 191.....
Burial Permit Oleek

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 19, 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 18 1920, to Nov 19 1920, that I saw her alive on Nov. 18 1920, and that death occurred, on the date stated above, at 3 20 A. m.

The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm J Schnot M. D.

Nov 19, 1920. (Address) 701 W Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cemetery	Nov 19, 1920
20-UNDERTAKER	ADDRESS
John F Tobey & Son	1318 Light

important. See instructions on back of certificate.

D48190

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48190

CERTIFICATE OF DEATH.

64

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1306 E. Chase ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Clifford

(Residence in Baltimore: No. 1306 E. Chase St.: yrs. 7 mos. 11 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, Nov., 11th., 1854
(Month) (Day) (Year)

7-AGE, 66 yrs. — mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). West Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank J. Clifford

(Address) 335 E. 30th. St.

15-

Filed NOV 19 1929, 191.... ROBERT B KRAUTER Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 18th, 1929
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy,

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

11-19-29 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Vincents Cem	11/20, 1929
20-UNDERTAKER	ADDRESS
P. Evans & Son	110 W. Read Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48191

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48191

CERTIFICATE OF DEATH.

REGISTERED NO. 15-91

1-PLACE OF DEATH Baltimore Md

CITY OF BALTIMORE: (No. 4249 Park Heights Ave. ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Martha M. Maaske

(a) RESIDENCE. No. 4249 Park Hts. Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? 37 yrs 6 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julius A. Maaske

6 DATE OF BIRTH (month, day, and year): Aug. 18th 1857

7 AGE — Years: 63 Months: 4 Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10 NAME OF FATHER: Ebony B. Somis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Canada

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't Know

14 Informant: Mrs Bechner (Address) 4249 Park Heights Ave

15 Filed NOV 19 1920 ROBERT E KRAUTER Registrar Burial Permit 07875

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 18th 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31st, 1920, to Nov. 18th, 1920, that I last saw her alive on Nov. 18th, 1920, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs.

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary): Broncho Pneumonia

(duration) — yrs. — mos. 25 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Fred H. Clark M. D.

. 19 (Address) 4249 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Nov 22 1920

20 UNDERTAKER: Philip Hennig — ADDRESS 2016 Aliceanna

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48192 HEALTH DEPARTMENT—CITY OF BALTIMORE D48192

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Montamore 20 ST.: 27 WARD) Raspeberg.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME anna Jane Katherine Klamenberg.

(a) RESIDENCE NO. Montamore Jackson ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Klamenberg.

6 DATE OF BIRTH (month, day, and year) Dec 3/15

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Hanover. Germany

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) Hanover.
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Hanover.
(State or country) Germany

14 Informant John Klamenberg
(Address) Montamore & Jackson Sts

15 NOV 19 1920 ROBERT E. McAULIFFE Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1920.

17 I HEREBY CERTIFY, That I attended deceased from Nov 7th. 1920. to Nov 17. 1920.

that I last saw h e alive on Nov 16 1920.

and that death occurred, on the date stated above, at 9.35 a. m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? at Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) George E. Hooper, M. D.

. 19 (Address) Gilmor and Hoffman Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	Nov 20 1920
20 UNDERTAKER Philip Henry	ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D48193

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48193

CERTIFICATE OF DEATH.

120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. New City Hospital ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Simms

(a) RESIDENCE. No. Unknown ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West River, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) New City Hospital.

15 Filed NOV 19 1920 19 ROBERT I. KRAUSE Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17, 1920

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1920 to November 17, 1920 that I last saw h er alive on November 17, 1920 and that death occurred, on the date stated above, at 9:50 A. m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis
Hypertension.

(duration) 20 yrs.? mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) 15 yrs.? mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No especial test.

(Signed) R Stevenson M. D.

11/17/20 (Address) New City Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn Cemetery	Nov 19 1920
20 UNDERTAKER	ADDRESS
Katie R. Williams	1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1648194 HEALTH DEPARTMENT—CITY OF BALTIMORE 1648194

CERTIFICATE OF DEATH.

91

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 N. Dallas ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME angela Fisher

(a) RESIDENCE. No. 1611 N. Dallas ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9.	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Fischer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Rose Liggins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Rose Fischer

(Address) 1611 N. Dallas st.

15 Filed NOV 19 1920 ROBERT J. CRAUTER Registrar

Burial Permit Given

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 14 1920, to Nov 17 1920.

that I last saw h alive on Nov 17 1920.

and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John W Anderson M. D.

, 19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Nov 8 1920

20 UNDERTAKER George J. Ruth ADDRESS 1755 Hanford Ave

L 48195 HEALTH DEPARTMENT—CITY OF BALTIMORE L 48195

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4002 Bell Av ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sallie R. Kennaman

(Residence in Baltimore: No. 4002 Bell Av. St.; 61 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): widow

6-DATE OF BIRTH, July (Month) 15 (Day), 1859 (Year)

7-AGE, 61 yrs. 5 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 069
(a) Trade, profession, or particular kind of work: sewing teacher
(b) General nature of industry, business, or establishment in which employed (or employer): Public Schools

9-BIRTHPLACE, (State or Country): Maryland,

PARENTS.

10-NAME OF FATHER: Amos Evans

11-BIRTHPLACE OF FATHER (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Anna E. Mitchell

13-BIRTHPLACE OF MOTHER (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jones (daughter-in-law)

(Address) 4002 Bell Ave.,

15-

Filed NOV 19 1920 191.... ROBERT B KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 17 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

5 minutes

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. E. D. Hennessy M. D. (Coroner.)

Nov. 19..., 1920 (Address) 4602 Eutaw Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Louden Park DATE OF BURIAL, Nov 20, 1920

20-UNDERTAKER Jonah Yeffer ADDRESS 1600 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

1648196 HEALTH DEPARTMENT—CITY OF BALTIMORE 1648196

CERTIFICATE OF DEATH. X 150

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1659 N. North ST.; 15 WARD)

2-FULL NAME Edith Marden Ridout

(a) RESIDENCE. No. 97 Cathedral ST., Annapolis Md WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 ~~Single, Married~~, Widowed, ~~or Divorced~~ (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Thomas Ridout

6 DATE OF BIRTH (month, day, and year) 23 Aug 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	3	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Nothing VOD
(b) General nature of industry, business, or establishment in which employed (or employer): ~~Housekeeper~~.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Josie Marden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Amanda Bond

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Annie Dorsey
(Address) 1602 W Saratoga

15 NOV 19 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-18- 1920

17 I HEREBY CERTIFY, That I attended deceased from Oct-22, 1920, to Nov-18-, 1920, that I last saw h alive on Nov-17, 1920, and that death occurred, on the date stated above, at 2-15 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 5 yrs. ~~mos.~~ ds.

CONTRIBUTORY (Secondary) acidosis Pneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chemical

(Signed) Emma Jones, M. D.

19 (Address) 2802 Roslyn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Whitehall Md	Nov 20 1920

20 UNDERTAKER: Josiah Lyfer

ADDRESS: 16 a W North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

1048197 HEALTH DEPARTMENT—CITY OF BALTIMORE 1048197

CERTIFICATE OF DEATH. 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Carlyle Place ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Turpin

(a) RESIDENCE. No. 1717 Carlyle Place ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Single

5a If married, widowed, or divorced HUSHAND of (or) WIFE of None.

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
29	Years	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor. 040

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jhn. H. Turpin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Henretta Chamb[illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Father Florist (Address) 1717 Carlyle place.

15 Filed NOV 19 1920 ROBERT B KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1920, to Nov. 18, 1920, that I last saw him alive on Nov. 18, 1920, and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis & Haemorrhage of Lung. Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis & Bronchitis

(duration) yrs. 6 mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. W. Kennard, M. D.

11-19 1920 (Address) 708 Enson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Delbury. Cemetery. Nov. 21	1920
20 UNDERTAKER	ADDRESS
Milton. Davis. 413. N Eden St	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

2048198 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓2048198

CERTIFICATE OF DEATH. X 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Preston

(a) RESIDENCE. No. Chesapeake Ave., Towson ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33			

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Preston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucy Nixton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed NOV 19 1920 ROBERT B KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17, 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1920, to Nov. 17, 1920, that I last saw h[illegible] alive on Nov. 16, 1920, and that death occurred, on the date stated above, at 7.20 [illegible] m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous osteomyelitis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. F. Rigney, M. D.

11-17-20, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Ridge Cem. Towson	Nov. 20 1920
20 UNDERTAKER John Burns Sons	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48199 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48199

CERTIFICATE OF DEATH. 43

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 3625 Mayle Ave St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minerva Rappoldt

(a) RESIDENCE. No. 3625 Mayle Ave St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Rappoldt

6 DATE OF BIRTH (month, day, and year): Oct 27 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: George Gaithe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Andrath

13 BIRTHPLACE OF MOTHER (city or town) (State or country): West Va

14 Informant: George M Rappoldt

(Address) 3625 Mayle Ave

15 Filed NOV 19 1920, 19

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 18 1920

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1920, to Nov. 18, 1920, that I last saw h[e] alive on Nov. 17, 1920, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of breast

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes no. Date of July 4th 1920

Was there an autopsy?

What test confirmed diagnosis? Microscopic examination of tissue removed at operation

(Signed) Chas. H. Longacre, M. D.

11-18-1920 (Address) 370 Dover St & Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harrisonburg Va	Nov 20 1920

20 UNDERTAKER: Wm E Shenowethdon ADDRESS: 3617 Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48200 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48200

CERTIFICATE OF DEATH.

H 2

1-PLACE OF DEATH # REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 112 Augusta Av ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna K. Staack

(Residence in Baltimore: No. # 112 Augusta Av St.; 60 yrs., 7 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Aug 27th, 1860
(Month) (Day) (Year)

7-AGE, 60 yrs. 7 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 137

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Henry J Staack

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Schaefer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry J Staack M D

(Address) 249 Augusta Ave

15-
Filed NOV 19 1920 191 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 19, 1920.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 1 1920, to Nov. 19 1920, that I saw h alive on Nov 19 1920, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Ovarian Carcinoma

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion - Heart Failure

(Duration) ? yrs. mos. ds.

(Signed) Henry J Staack M D M. D.

Nov 19, 1920 (Address) 23 W Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery DATE OF BURIAL, Nov 20, 191...

20-UNDERTAKER 405 Hilliard=2236 Eutaw Pl ADDRESS

Spaces must be filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D48201

HEALTH DEPARTMENT—CITY OF BALTIMORE

D48201

104

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1852 N Rolfe Ln ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Cornelius Hortiman

(Residence in Baltimore: No. 1852 N Rolfe Ln St.; ....yrs. ....mos. ....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, September 18th, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 0 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph D Hortiman

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Grace M Cole.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph D. Hortiman

(Address) 852 N Rolfe St.

15-

NOV 19 1920, 191.... Robert P. Harrison, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 18th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 7th 1920, to Nov. 18th 1920, that I saw h.. alive on Nov 18th 1920, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ....yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo Morgan Otto M. D.

Nov 18th 1920 (Address) 401 E 20th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Carmel	Nov. 20th, 1920.
20-UNDERTAKER J. M. Cole	ADDRESS 417 N Mt

D.48202

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48202 HEALTH DEPARTMENT—CITY OF BALTIMORE

64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1313 Morling Ave. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane McCauley.

(a) RESIDENCE. No. 1313 Morling Ave. ST. 13 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 9 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert B. McCauley

6 DATE OF BIRTH (month, day, and year) Jan. 25-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER Mathias Haupt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Rebecca Granger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Charles E. McCauley
(Address) 1313 Morling Ave.

15 Filed NOV 19 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 1920.

17 I HEREBY CERTIFY, That I attended deceased from Nov 6 1920, to Nov 18 1920, that I last saw h.. alive on Nov 18 1920, and that death occurred, on the date stated above, at 8 55 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage & general Paralysis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) arterio-sclerosis

indefinite (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sudden unconsciousness

(Signed) Clovanides Stewartz, M. D.

Nov 18 1920 (Address) 865 - W. 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Nov. 20 1920
20 UNDERTAKER	ADDRESS
Horace Burgee & Son	3631 Falls Rd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48203

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48203

CERTIFICATE OF DEATH.

28

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 3605 Windsor Mill Rd St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia C. Lucke.

(Residence in Baltimore: No. 3605 Windsor Mill Road St.; 69 yrs., 3 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	W.	Married

6-DATE OF BIRTH, July (Month) 27 (Day), 1851 (Year)

7-AGE, 69 yrs. 3 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, John Seiger

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Mary Weber

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rudolph H Lucke

(Address) 3605 Windsor Mill Rd.

15-

Filed NOV 19 1920, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 18 (Day), 1920 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1 1918, to Nov. 18 1920, that I saw he alive on Nov. 18 1920, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Fatal

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) acute Bronchitis

(Duration) ....yrs. ....mos. 1 ds.

(Signed) Jno A Fuetsch M. D.

NOV. 19, 1920 (Address) 1025 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Nov 20 ....., 191...
20-UNDERTAKER	ADDRESS
George Fuhrman	1000 Madison Ave

Type or write plainly in ink. Cause of death must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.48204

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D.48204

64

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No 2205 Blair Rd ST. 8 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME HUGH. PIERCE

(Residence in Baltimore: No. 22005 Blair Rd. St.; 10 yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
M	W	M

6 DATE OF BIRTH April 21, 1866
(Month) (Day) (Year)

7 AGE 54 yrs. 6 mos. ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) None 000

9 BIRTHPLACE (State or country) Md.

PARENTS

10 NAME OF FATHER Wm H Pierce

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret McGuigan

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Martha Pierce

(Address) 2205 Belair Rd

15. Filed NOV 18 1920, 19 Robert P. Harrison, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11 (Month) 18 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17, 1920, to Nov 18 1920, that I saw him alive on Nov 18, 1920, and that death occurred, on the date stated above, at 4A m.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage - mid brain L causing paralysis Right side of body - left eye ptosis. (Duration) ..... yrs. ..... mos. 1 ds

Contributory (SECONDARY) Hypertension - (Duration) 2 yrs. ..... mos. ? ds.

(Signed) J H McCarty M. D.
Nov 18, 1920 (Address) 537 W. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Chester Pa.	Nov 20, 1920
20 UNDERTAKER	ADDRESS
H M Rowson	2238 N Monta

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48205

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48205

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S.P.H.S.Hospt #56 ST.: Ft. McHenry WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Beverely Watson

(a) RESIDENCE. No. Edgewood, Md. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 2 mos. dys. How long in U. S., if of foreign birth? yrs. mos. dys.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam fitter

(b) General nature of industry, business, or establishment in which employed (or employer) -------

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edgar T. Rosenbush (Address) Ft. McHenry, Baltimore, Md.

15 Filed NOV 19 1920, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1920 19 to Nov. 19, 1920 that I last saw him alive on Nov. 19, 1920 19 and that death occurred, on the date stated above, at 4:30 AM

The CAUSE OF DEATH* was as follows:

Tuberculosis, chronic pulmonary
(Active, far advanced)

(duration) Unknown mos. dys.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. dys.

18 Where was disease contracted if not at place of death? Edgewood Arsenal

Did an operation precede death? No Date of ---

Was there an autopsy? YES

What test confirmed diagnosis? ----

(Signed) Thomas R. Payne (Surgeon(R)) M. D.

11/19 19 26 (Address) Fort McHenry, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cmet. DATE OF BURIAL Nov. 20 19 26

20 UNDERTAKER A. Emerson's Bro ADDRESS 1127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48206 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48206

CERTIFICATE OF DEATH. 104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 W. Hamburg ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Savoy

(a) RESIDENCE. NO. 226 W Hamburg ST., 23 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Savoy

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Viola Sharps

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm Savoy
(Address) 226 W. Hamburg St

15 [illegible] Robert P. Harrison, Registrar

NOV 19 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/18/ 1920

17

I HEREBY CERTIFY, That I attended deceased from Nov 14th, 1920, to Nov. 18th, 1920, that I last saw her alive on Nov. 17th, 1920, and that death occurred, on the date stated above, at 12:05 a m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum
about 2 months (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro Enteritis
about 2 weeks (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Guy Bowley, M. D.

11/18/ 1920 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 20 1920
20 UNDERTAKER	ADDRESS 142
Jno. H. Toadvine	W Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48207 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48207

CERTIFICATE OF DEATH. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 Oakhurst Place St.. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christian William Kestner

(a) RESIDENCE. No. 1202 Oakhurst Place St.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married Katie Kestner

6 DATE OF BIRTH (month, day, and year): Dec. 29 - 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	10	19	

8 OCCUPATION OF DECEASED 045

(a) Trade, profession or particular kind of work: Manufacturer of Cigars

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Henry Kestner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Fredericka Wiekenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Katie Kestner (Address) 1202 Oakhurst Place

15 NOV 20 1920 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4 1920, to Nov 18, 1920, that I last saw him alive on Nov. 17, 1920, and that death occurred, on the date stated above, at 1 30 P m.

The CAUSE OF DEATH* was as follows:

Atropic Cirrhosis of Liver

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Endocarditis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry Boyd, M. D.

Nov 20 1920 (Address) 847 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov. 20 1920
20 UNDERTAKER	**ADDRESS**
Philip Seewald & Son	825 W. North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.48208

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48208

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 18 WARD) REGISTERED No. C 167

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernice Holmes

(Residence in Baltimore: No. 816 W Pratt St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, April 24, 1916 (Month) (Day) (Year)

7-AGE, 4 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work. born
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Bath Co

PARENTS.

10-NAME OF FATHER. John Holmes

11-BIRTHPLACE OF FATHER (State or Country). S. C.

12-MAIDEN NAME OF MOTHER Ethel Mills

13-BIRTHPLACE OF MOTHER (State or Country), S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 716 Pine

15-

Filed NOV 6 1920, 191

Robert P. Harrison,
Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 18, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or,~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ topsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Clothes Caught fire playing with matches, burns over entire body (Duration) yrs. 4 hrs mos. ds.

CONTRIBUTORY (Secondary) Accidental Asphyxia (Duration) yrs. 4 hrs mos. ds.

(Signed) W. R. Jones M. D. (Coroner.)

11-19, 1920 (Address) 117 W. Saratoga

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Nov 20 1920
20-UNDERTAKER	ADDRESS
Daniel Easton	716 Pine

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Andrzejczuk

D.48209

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48209

CERTIFICATE OF DEATH.

33

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 705 S Regester ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Andrzejczuk

(a) RESIDENCE. No. 705 S Regester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 22 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wladyslaus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Jaczuk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Wladyslaus Andrzejczuk
(Address) 705 S Regester

15 NOV 20 1920 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1920, to Nov 19th, 1920, that I last saw h.m alive on Nov 18, 1920, and that death occurred, on the date stated above, at 5 0 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A L Tumbleson, M. D.

Nov 19 1920 (Address) 2013 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Holy Rosary	
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

CAUSE OF DEATH should be stated EXACTLY. AGE should be stated in years, months and days. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D.48210 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48210

CERTIFICATE OF DEATH.

REGISTERED No. C 91

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1841 Lorman ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rogus Octavius Moulden

(Residence in Baltimore: No. 1841 Lorman St.; yrs., 10 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH, January 6, 1920 (Month) (Day) (Year)

7-AGE, ... yrs. 10 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... (Infant)

9-BIRTHPLACE. (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Rogus C. Moulden

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Clara Johnson

13-BIRTHPLACE OF MOTHER (State or Country), N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rogus C. Moulden

(Address) 1841 Lorman St.

15- Robert P. Harrison,

Filed ..... 191 Burial Permit Clerk, Registrar.

NOV 20 1920

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 17, 1920 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Hennessy M. D. (Coroner.)

Nov. 18, 1920 (Address) 2802 Eastmondumber

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Nov 20 1920

20-UNDERTAKER Edward Ringgold ADDRESS 1463 N Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate.

D. 48211

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 48211

CERTIFICATE OF DEATH.

64

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Elm Ave My 31 St.: 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Blanche C. Small

(Residence in Baltimore: No. 810 Wellington St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, Aug 21, 1875
(Month) (Day) (Year)

7-AGE, 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Balto.

PARENTS.

10-NAME OF FATHER, John Carr.

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Susan Burns

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry S. Small

(Address) 810 Wellington St

15-

NOV 23 1920

Filed, , 191

Robert P. Harrison,
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 18, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the date stated above.

The CAUSE OF DEATH* was as follows:

a Fr Pleurisy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas Morrison M. D.
(Coroner.)

Nov 20, 1920 (Address) 532 Robinson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loraine Cem	Nov 22, 1920
20-UNDERTAKER	ADDRESS
E. F. Lindsay	1001 E 22 St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48212

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48212

CERTIFICATE OF DEATH.

10-091

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3112 E. Fayette ST.: 6 WARD)

2-FULL NAME Marion R. Lofferberth

(a) RESIDENCE. No. 3112 E. Fayette ST., WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 6th 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1		12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Harry E. Lofferberth

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Storch

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Harry E. Lofferberth
(Address) 3112 E. Fayette St.

15 Filed ....., 19 Robert P. Harrison, Registrar

NOV 20 1920

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1920, to Nov 18, 1920, that I last saw h[illegible] alive on Nov 18/20, 19....., and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Exam.

(Signed) [illegible] M. D.

Nov 19 20 (Address) 1100 N Ludwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Nov 20 1920
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.48213

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48213

154

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1930 Hanover St. 23 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bowers

(a) RESIDENCE. No. 1930 Hanover St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 74 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Widow of Catherine Bowers

6 DATE OF BIRTH (month, day, and year) May 5, 1834

7 AGE: Years 86 Months 6 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Cooper

(b) General nature of industry, business, or establishment in which employed (or employer): Cooper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ellicotts City Md

PARENTS

10 NAME OF FATHER: Julius Bowers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): George E Bowers 1930 Hanover St

15 Filed NOV 20 1920 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1920

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1920, to Nov 19, 1920, that I last saw h[illegible] alive on Nov 19, 1920, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Senility

Old age

1 (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) T. H. T. Carnahan, M. D.

Nov 19, 1920 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem & Nov 22	1920
20 UNDERTAKER	ADDRESS
W. M. Baker & E. Northam	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48214 HEALTH DEPARTMENT—CITY OF BALTIMORE D.48214

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 Franklin St.; 19 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E Farrell

(Residence in Baltimore: No. 1515 Franklin St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, November, 1866
(Month) (Day) (Year)

7-AGE, 64 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), New Jersey

PARENTS.

10-NAME OF FATHER, James F Farrell

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Ann McGuirk

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M J Farrell

(Address) 1515 Franklin

15- Robert P. Harrison,
(Date) ....., 191.....
Burial Permit Clerk. Registrar.

NOV 8 0 1920

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 18, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1920, to Nov 18 1920, that I saw h- alive on Nov 17 1920, and that death occurred, on the date stated above, at 1.30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach
4 Yrs —
(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Intoxication
(Duration) yrs. mos. 1 ds.

(Signed) Edward Mandelbaum M. D.
11/19/20, 191... (Address) 74 W Fallsway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem

DATE OF BURIAL, 11-22 191..

20-UNDERTAKER. Fr A Talley

ADDRESS Fulton Fayette

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D.48215

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.48215

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 N. Eutaw St.; 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edmonia Lindsay

(Residence in Baltimore: No. 1021 N. Eutaw St.; 11 yrs., ... mos. ..... ds.)

Properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... Unknown ....., 1877
(Month) (Day) (Year)

7-AGE, 43 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE, (State or Country), Alexandria Va

PARENTS.

10-NAME OF FATHER, Wm Banks

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Jennie Banks

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Lindsay Jr.

(Address) 1021 N. Eutaw St.

15-

NOV 20 1920

Rec'd ....., 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 17th, 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10th 1920, to Nov 17th 1920.

that I saw h er alive on Nov. 17th 1920,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

..... (Duration) ... yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) Chas. J. Keller M. D.

Nov 19th, 1920 (Address) 2 W. Mulberry St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Alexandria Va. DATE OF BURIAL, Nov 22 191...

20-UNDERTAKER Samuel Tensley ADDRESS 57 E Baltimore St

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

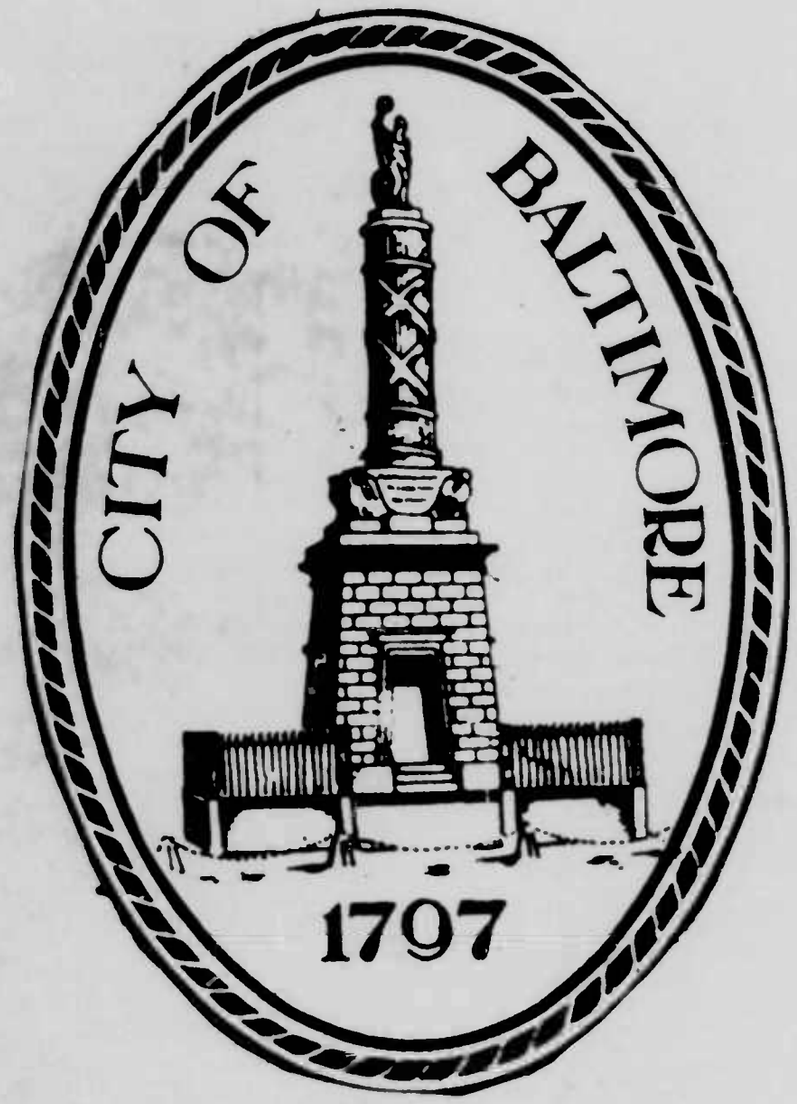
RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 7th DAY December
OF 1964 THE MICROPHOTOGRAPHS APPEARING
HEREIN STARTING WITH #D 44904 July 19, 1920 AND
ENDING WITH #D 48215 Nov. 20, 1920 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE
RECORDS OF THE DEPARTMENT OF Health
BUREAU OF Vital Statistics AS DELIVERED
IN THE REGULAR COURSE OF BUSINESS FOR
PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM
MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU
OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC
COPY.

CAMERA OPERATOR: D. McFaul



END OF REEL